STUDY COMMITTEE ON AGING

PUBLIC HEARING

SEPTEMBER 24, 1981

PUBLIC HEARING

BY

STUDY COMMITTEE ON AGING

Columbia, September 24, 1981

Senator Hyman Rubin, Chairman

TABLE OF CONTENTS

The Annual Public Hearing of the Joint Legislative Study Committee on Aging was held in the Blatt House Office Building, Room 101/110, in Columbia, South Carolina, on Thursday, September 23, 1981. The Hearing convened at 10 A.M.

Senator Hyman Rubin, Chairman of the Committee, called the Hearing to order and extended a cordial welcome to everybody.

In his opening remarks he mentioned that some of the subject matters have come up before and will come up again, because in some cases a great deal of funding is involved. "But it is good that we continue to hear about it and address ourselves to these problems. In a Democracy, if you keep thinking and talking and working, you can achieve solutions." Quoting Abraham Lincoln who observed that "public opinion in this country is everything," Senator Rubin said that more and more civic, church and private groups, as well as governmental agencies are very much attuned to the concerns of the elderly and that the Committee is getting more cooperation than ever before.

He explained that the function of the Committee is not merely to provide implementation and funding or being an advocate for desirable legislation, but it also serves an educational process by putting in the background stereotypes about older people, such as "being over the hill." "Each individual is different and some in their seventies can be more fit than some in their forties." The object is to provide a good life, good opportunities and at all times the opportunity for self-fulfillment.

In reviewing the past legislative session, Senator Rubin said that the Committee has had another good year. The Homestead Tax Exemption Acts have been further refined so as to provide for a one-time application for Homestead Tax Exemptions. The Community Long Term Care Project has gone extremely well. This is the pilot project in Cherokee, Union and Spartanburg Counties which is to provide a system of health services for the elderly in their homes through screening and assistance and thereby reducing the number of those who otherwise would have to go to nursing homes. The progress of this project has resulted in the Budget and Control Board's substantially increasing the State appropriation, which go along with Federal matching funds, in order to phase it in on a statewide basis. Senator Rubin stated that we

are very fortunate to have the Governor as Chairman of the Budget and Control Board and having been a former Chairman of this Committee, "we have a friend in Court."

The members of the Committee who were present were introduced: Dr. Julian Parrish, a gubernatorial appointee; Reverend Jack Meadors, gubernatorial appointee, who had just moved to Columbia as District Superintendent of this district in the Methodist Church; Senator Bill Doar, representing Georgetown and Charleston Counties; Representative Hudson Barksdale, Spartanburg County; Senator Peden McLeod, representing Allendale, Beaufort and Colleton Counties; Mrs. Gloria Sholin, another gubernatorial appointee; and staff members.

He recognized representatives from the various State agencies, who have been very cooperative, as well as other guests present.

Further, Senator Rubin made mention of a directory published by the Study Committee on Aging in cooperation with the Commission on Aging, entitled: State Services for Senior South Carolinians. This is an excellent reference which lists some forty (40) State Agencies that offer programs of assistance to the elderly. It is available through the Study Committee on Aging.

At this point, Senator Rubin read a letter from the Governor, which had been handed to him this morning. The letter commends the Chairman and the other members of the Committee for the good work during the past year. An important announcement was the creation of a Resource Panel on the Elderly in the next few weeks. This Panel will study the future needs of the elderly in South Carolina regarding their health and social needs. (Copy of the Governor's letter is attached to this transcript, see pages 3 and 4).

State of South Carolina

Office of the Governor

RICHARD W. RILEY
GOVERNOR

POST OFFICE BOX 11450
COLUMBIA 29211

September 24, 1981

The Honorable Hyman Rubin, Chairman
Joint Legislative Study Committee
on Aging
Room 305, Gressette Building
Columbia, South Carolina 29201

Dear Hyman:

Thank you for forwarding a copy of the 1981 Annual Report of the Legislative Study Committee on Aging. I want to commend you and the other members of the Committee for your good work during the past year.

In the past year we have devoted special attention to health care costs and the need for a statewide long term care policy. The Budget and Control Board has given tentative approval for the state match needed for statewide implementation of the Community Long Term Care Assessment and Service Management System. This is the first statewide step in meeting our shared goal of providing for an effective long term care service system which meets the needs of our elderly citizens. The Committee's long standing and active support will be needed during the appropriation process to help retain the funding for this initiative.

In the next few weeks, I will be creating a Resource Panel on the Elderly to study the future needs of the elderly in South Carolina. The most recent statistics indicate that there are approximately 416,000 persons in South Carolina over 60 years of age which is approximately a 45% increase in this population from 1970. We need to devote time now to collectively work on action which needs to be taken during the next several years to help us prepare for future needs of this population.

The Honorable Hyman Rubin
September 24, 1981

The Resource Panel will be primarily preventive in its approach to health and social issues, seeking realistic and attainable solutions. It will also address the long term issues involved in a changing economy and an increasing elderly population. The Resource Panel will give consideration to the needs of all income levels, including the near poor and middle income levels. As the Resource Panel develops its strategy and begins its work we will keep the Committee staff informed and involved. We will appreciate your support and expertise during this process.

The legislative Study Committee on Aging has historically been instrumental in providing the leadership required to bring about needed legislative action by the General Assembly. We applaud you on your continuing efforts in this area.

Yours sincerely,

Dick Riley

Richard W. Riley

RWR:SPL:g

Gerald L. Euster, D.S.W., Professor
College of Social Work
University of South Carolina
Columbia, SC 29208

The first part of Dr. Euster's statement dealt with a proposal which he had submitted to the Office of the State Administrator, entitled "Community Based Continuing Education for the Elderly." This project was designed to offer non-credit, tuition-free short courses for the cultural enrichment and personal enhancement of elderly citizens in Lexington-Richland Counties. Courses were designed to facilitate the "continuous" and "lifelong" learning process of interested elderly citizens who otherwise might be unable to participate in educational opportunities through traditional "on campus" learning methods.

Unfortunately, because of decisions made within the Reagan Administration to eliminate all federal funding of Continuing Education Outreach Programs for the elderly, the implementation of this Project, on which Dr. Euster had worked almost an entire school year, has been delayed.

The second part of his statement addressed the furthering of our commitment to the elderly to provide adequate professional care and services in our health, education and welfare system.

On the eve of the 1981 White House Conference on Aging, we have merely begun the work of fulfilling the mandate of the 1971 Conference; i.e., to escalate programs and services that promote hope through development opportunities for the elderly.

He emphasized the following points:

1. Need for legislation that will promote developmental opportunities for the elderly in this State.
2. Supportive legislation of pre-retirement services.
3. Expanded development of multipurpose senior centers.
4. Day hospitals and day care programs.
5. Legislative support for the operationalization of effective psychosocial rehabilitation activities.

(Dr. Euster's full statement follows the questions by Committee Members).

Representative Barksdale referred to Dr. Euster's mention of the White House Conference on Aging. He asked if this is a perfunctory meeting at the White House or does it accomplish something worthwhile.

Dr. Euster expressed his hope that the delegates to this Conference from South Carolina will emphasize the need to really stay committed to the objectives that will be set forth.

"Why have the 1971 commitments not been carried out, was it lack of funds, or what," asked Representative Barksdale.

Dr. Euster attributes this to lack of funds, understanding of the proposals that have been made--a lot of reasons why we are still trying to catch up.

Representative Barksdale stated that in his opinion this is just an opportunity for senior citizens to get to the White House to see the President...

Senator Rubin thanked Dr. Euster for his statement and added that the Legislature has provided the elderly with the opportunity to attend institutions of higher learning, age 60 and over, without tuition on a space available basis. However, he finds that this is little known, and it seems that the institutions have not gotten the word out.

To: The Honorable Senator Hyman Rubin, Chairman, and Distinguished Members of the South Carolina Study Committee on Aging

Thank you for providing me this opportunity to present testimony before the Study Committee on Aging.

I have been deeply distressed in recent months because of decisions made within the Reagan Administration to eliminate all federal funding of Continuing Education Outreach Programs for the Elderly. Funding in this area formerly had been provided under Title IB, Higher Education Act of 1965, with grants awarded in our state by the South Carolina Commission on Higher Education. Projects were administered by the Office of the State Administrator, Community Service-Continuing Education, Title IB. Our South Carolina project personnel, John J. Powers and Roland C. Dubay, were doing an outstanding job of encouraging highly innovative project proposals for our elderly citizens and in awarding grants for their implementation.

In September, 1980, I submitted a Preliminary Proposal entitled "Community Based Continuing Education for the Elderly" to the Office of the State Administrator. Subsequently, I was encouraged to provide a Final Project Proposal for consideration by the review panel. The Final Proposal was delivered to the State Administrator on May 8, 1981.

The Project was designed to offer non-credit, tuition-free short courses for the cultural enrichment and personal enhancement of elderly citizens in Lexington-Richland Counties. Specially tailored learning experiences, based upon the needs and interests of the elderly population, would be offered in "outreach" learning centers by skilled University of South Carolina faculty and community instructors. Courses would be designed to facilitate the "continuous" and "lifelong" learning process of interested elderly citizens who might otherwise be unable to participate in educational experiences through traditional on-campus learning structures.

The project was aimed at involving older learners in congregate meal site programs, housing projects, senior centers, libraries, and nursing homes already formed into natural groups and with access to program facilities. Older adults, willing and able to attend on-campus courses, would be helped to enroll and take advantage of existing courses as well as newly created learning opportunities within the university system. The project further aimed at establishing a planning, coordination, and organizational mechanism to assist aging groups and agencies gain continuing access to educational opportunities.

I wish to emphasize the elderly populations who were to be served by the project:

Physically handicapped and other less mobile senior adults would have been formed into classes at various community-based learning centers (churches, nursing and retirement homes).

Natural groups of seniors would have received courses in such settings as community centers, senior centers, and libraries.

Congregate meal participants would have been provided educational opportunities on a regular basis at 13 meal sites in Richland-Lexington Counties.

Mobile seniors would have been provided selected courses on the campus of the University of South Carolina. All efforts were to be made to involve these learners in regular university programs. Senior learners would have been granted greater access to postsecondary education, the freedom to select courses and experiences which were personally meaningful, and opportunities for continuing growth and development.

Among the many specially designed courses to have been offered were the following:

-- Physical Fitness for Older Adults
-- Nutritional Information for Older Adults
-- Creative Arts and Crafts for the Homebound Elderly
-- Consumer Protection for the Elderly

-- Home Maintenance for Older Homeowners
-- Community Resources for the Elderly
-- Reading for Pleasure
-- Blacks in Contemporary Society: Sports, Arts, and Sciences
-- Estate and Will Planning
-- South Carolina: The Future of Our State
-- Television: Wasteland or Gold Mine?
-- Achieving Personal Growth as a Senior Adult

From October, 1980 through April, 1981, almost an entire school year, my efforts were directed toward a clearer conceptualization of the proposed service project and achieving the necessary community linkages and support to offer this developmental program to elderly citizens in Richland and Lexington Counties. I am grateful to the following agencies who provided advice, encouragement, and/or agreed to cooperate in facilitating the proposed educational project:

1. The South Carolina Commission on Aging
2. Richland-Lexington Council on Aging
3. Central Midlands Regional Planning Council
4. Lexington County Public Library
5. South Carolina Department of Social Services
6. University of South Carolina, Center for Nontraditional Studies and Educational Referral Services
7. The South Carolina Episcopal Home
8. The South Carolina Study Committee on Aging

I am convinced that my ideas were sound and that community interest was high. Obviously, the timing was poor. Mr. Reagan and Mr. Stockman have forcefully convinced a lot of Americans that funding in this and other human service areas is no longer a priority of the federal government. Indeed, they are suggesting that the private sector assume greater responsibility for tackling "people priorities."

I have come before this distinguished caring committee today, not to bemoan what has happened to delay implementation of Educational Outreach to the Elderly. Instead, I have come to project some "caring" ideas at a time when many would want us to believe that caring is out of style, not the responsibility of government, and no longer a sufficient justification for shaping our social welfare policies.

FURTHERING OUR COMMITMENT

It is widely acknowledged that until very recently the elderly received less than adequate professional care and services in our vast health, education, and welfare system. Many persons still believe, I must add, that the needs of the elderly in our society continue to be met, at best, begrudgingly. We have witnessed, often deplored, and, for the most part, begun to counteract our culture's negative attitudes toward the aged. We have made a marvelous beginning to alter society's tendency to systematically stereotype and discriminate against the elderly. Tremendous movement has been made to improve the quality of life for residents of nursing homes and other institutional settings. Indeed, social welfare planners, human service professionals, and legislators have thoughtfully considered and structured alternative programs and provisions to assist the elderly in their natural environments. Here we are, though, on the eve of the 1981 White House Conference on Aging, and we have merely begun the work of fulfilling the mandate of the 1971 Conference, to escalate programs and services that promote hope through development opportunities for the elderly.

I wish to emphasize the need for legislation that will promote developmental opportunities for the elderly in our state. Developmental services are preventive in that they enable the elderly to maintain their personal and social well-being through the use of social-interactional, educational, and meaningful work activities. Such activities enable the elderly to view their "aging" as a time of new opportunities, fulfillment, and growth, and not as a period of conflict, sadness, and decline in functioning.

Legislation should be supportive of Pre-retirement services in family agencies, community centers, senior centers, and industrial settings, to help pre-retirees deal with such issues as financial planning, use of leisure time,

the meaning of retirement, changes in physical functioning and participation in community affairs.

Expanded development of multipurpose senior centers to insure social-recreational, educational, and creative-expressive opportunities for those elderly citizens desiring to broaden horizons and increase community participation. Such centers may serve as learning centers as well as to both sponsor and coordinate programs of volunteer community service by senior participants. Working closely with other community programs and agencies, the elderly may creatively be drawn into unique and responsible service roles with both younger and older populations.

Day hospitals and day care programs for those elderly suffering physical, mental, and social impairments and who do not require residential-institutional care. Such settings may provide a useful form of group environment for elderly persons unable to remain at home during the daytime hours, and for those requiring supportive group relationships and activities planned by multi-disciplinary personnel. Such programs may serve to prevent further deterioration and demoralization of those elderly who require interactional compensation for social role losses, not total removal from the community. South Carolina lags seriously behind the rest of the nation in this service area.

For those elderly who must live in long term care facilities I urge legislative support for the operationalization of effective psychosocial rehabilitation activities. Reality orientation, life review and reminiscence, and other forms of stimulating educational activity, have been shown to significantly modify the often motionless atmosphere of many long term institutions. Such activities may serve to counteract the threat of helplessness and hopelessness among many elderly who require meaningful social and learning outlets.

It is clear that obstacles to the emergence of qualitative developmental opportunities for the elderly are again on the horizon. The task before human services personnel, law makers, and social welfare planners is first and foremost to stay on course, continue to develop effective programs and services to reach the elderly, and actively strive to promote the healthy functioning of older adults in the community. We must continue to strive for an enforceable system of institutional accreditation so that we do not fall behind in creating restorative opportunities for the elderly. Social, recreational, and educational activities, woven into the fabric of institutional and community care, must be used as tools to reduce the boredom, silence, and hopelessness that preoccupies many elderly who no longer have sufficient interactional opportunities. We must continue to commit ourselves to our elderly population. Let us hope that caring never goes out of style.

Presented By

Gerald L. Euster, D.S.W.
Professor
College of Social Work
University of South Carolina
Columbia, South Carolina 29208

Dr. Hal French
Associate Professor
Department of Religious Studies
University of South Carolina
Columbia, SC 29208

Dr. French spoke on two issues:

1. The Natural Death Act. This seems to have become a "perennial" issue; however, he urged the Committee not to abandon it and to continue efforts toward passage.

2. He announced a Workshop, which the Department of Religious Studies, along with the University Chaplains, will sponsor next month. The theme of this workshop is "The Church and the Funeral," and its purpose is to explore current funeral practices and the church's ministry in death education.

Representative Barksdale voiced his strong objection to the Natural Death Act legislation, made by people at the time of a terminal illness.

Dr. French explained that this Act may be made by people in advance of any illness and not only at the time of illness; this would indicate a policy made over a period of time and, again, in consultation with others.

Representative Barksdale replied that being a senior citizen himself, he knows that he does not think the way he did when he was younger. "As you get older, you become more reasonable and see things in a different light."

Senator Rubin added that the legislation got through the Senate; however, it failed several times in the House. It appears that we have to wait for enough support and sentiment in South Carolina that may ensure passage.

Dr. Parrish asked if an extensive education program is necessary to implement the second recommendation, dealing with Federal regulations of the funeral industry.

Dr. French said that an educational effort can and will be made in this connection. They are anticipating it to some extent and putting it on the agenda for South Carolina for next month. This is in advance to those Committee recommendations being made to Congress. But they will be made, and Dr. French hopes they will be useful.

Dr. Parrish--referring to a statement by Dr. French that recommended regulations have grown out of an eight-year study of funeral industry practices--said that he happened to know about this subject from many years before. There were professors in New York who wrote on the same issue, and it has not progressed as fast as an idea should progress. The needed ingredient, in his opinion, is to recommend that this Committee assist with an education program.

Dr. French replied that he would be glad to see that implemented in their recommendations.

(Dr. French's statement and announcement of workshop are on the following pages).

Senator Rubin thanked Dr. French for his presentation. He, then, acknowledged the presence of Mr. Joe Matthews, Administrator, Stroud Nursing Home, Marietta, South Carolina. This facility is a leader in the not-for-profit nursing industry in South Carolina. He, also, introduced Representative Dill Blackwell.

Statement to the Legislative Committee on Aging, Sept. 24, 1981
Dr. Hal W. French, Associate Professor, Dept. of Religious Studies, USC Columbia

Mr. Chairman, Members of the Committee, Friends:

I'd like to speak to two matters which are of particular concern to the elderly, and also to the citizenry at large. The first is an item of legislation which this committee has championed over the last few years through different legislative strategies. I wish to commend you for your efforts on behalf of the passage of the Natural Death Act. To use the language of the bill in a reverse way, its passing has been difficult, and the temptation now may be to let it die a natural death. I would urge you, however, to employ heroic measures to effect its resuscitation. It cannot yet be judged to be terminal.

This may already seem, again, a perennial issue, to be lumped with other "lost causes" which should be abandoned. But I would remind the Committee that the first such law was enacted in the United States only five years ago, and that nine other states have enacted similar laws in the years remaining. This is still a young issue. It might not impress us that the first of these was California. We expect California to pass radical measures. It may impress us, however, that the most recent state to adopt such legislation, in 1979, was Kansas, which cannot be judged to be the most progressive state on certain legal issues, having been one of the last two states in the union to repeal prohibition. I speak as a proud and loyal native son of that great state in making this observation. Similarly, Arkansas , North Carolina and Texas would not usually be thought of as given to radical causes, yet these states are among those which have enacted such laws. I would urge now that my adopted state of South Carolina be one of those pioneering in the enactment of this humane piece of legislation.

My own concern for this measure stems from having taught a course at the University on death and dying since 1976, a course in which over 500 persons have been enrolled. This issue has been explored in detail each time the course has been offered, along with other ethical issues related to death. I have heard discussions, I have read journals and exams, and I can state categorically that the vast majority of this sampling of concerned people, mostly young people, almost approaching unanimity, is in support of this legislation. Why? Why this near unanimity on a topic which is admittedly controversial? Having studied it, these persons want to have control over the circumstances of their dying as well as their living. It is a very real spectre to young people, and to others I've encountered in speaking to church and community groups, to imagine themselves, on some occasion, comatose, terminal, indefinitely prolonged in their dying through artificial means, being victimized by the medical technology which should assist their life quality. If given the opportunity, they would deem it their right to indicate, in advance, that this would not be their wish, and to give their reasoned choice binding legal weight.

I quote, for the consideration of those present, a part of the language of the declaration which a person in question might choose to sign. Similar language is found in almost all such measures thus far enacted by the various legislatures.

> "If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, . . . and the physicians have determined that my death will occur whether or not life-sustaining

French,

> procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performanceof any medical procedure deemed necessary to provide me with comfort care.

I would submit to all parties concerned that this is my right, and the right of every person who would choose it, to what that person may deem his or her own natural death.

The second matter which I would like to address concerns a workshop which my Department, the Department of Religious Studies, along with the University Chaplains, will sponsor next month. The workshop, on the Church and the Funeral, will have the cooperation, also, of the Columbia Ministerial Association and the Lutheran Southern Seminary, and is partially funded by a small grant by the South Carolina Committee for the Humanities. This constitutes an announcement; I am not proposing legislation, although the workshop will consider pertinent legislation which is pending at the national level.

Just as aging persons are concerned about the process of dying, that they may exert some measure of control over their own circumstances, so are we all properly concerned that we be given the best information in order to make responsible choices about what happens after death; I refer to the very practical decisions which must be made concerning funeral arrangements.

The Federal Trade Commission, in the next few months, will submit for Congressional approval, a list of recommended regulations for the funeral industry. These grow out of an eight year study of industry practices. While by no means indicting the industry at large, the report recognizes the great vulnerability of persons who must make decisions at the time of death. Partially immobilized by grief, unable to shop or bargain, a majority of persons facing such responsibility for the first time, most people need more protection and help than we have customarily given them.

Again, drawing on the opinions of my students, when anticipating what they would want for themselves or for family members. I can report to you that three things surface: they want such funeral arrangements to be simple, natural and inexpensive. It is often difficult to implement these wishes, given current American funeral practices. The workshop will explore alternatives to present practices, with two guest speakers from England reporting on comparative practices there, as well as to study how the religious institution and other civic agencies may be more responsive to their role in helping persons to make knowledgeable choices and wise planning in this regard.

The Workshop will be held on Friday, October 23rd, at Washington Street United Methodist Church in Columbia. Interested persons may contact our Department at the University, 777-4100, for further information.

Thank you, ladies and gentlemen, for your consideration.

THE CHURCH AND THE FUNERAL

A Workshop at
Washington Street Methodist Church,
Washington and Sumter Streets, Columbia, South Carolina

Friday, October 23, 1981

PURPOSE: To explore current funeral practices and the Church's ministry in death education. The roles of the clergy and funeral professionals will be examined as these relate to the needs of the public generally. Consideration will be given to reform measures, in the light of recent FTC recommendations, and to alternative practices, through comparison with those in England.

RESOURCE PERSONS:

Eric Spencer and Edward Field, Director and Chairman, respectively, of the Great Southern International Group of Funeral Directors in England, which handles some 5% of the funerals annually in England and Wales. They will be returning from speaking at the American Cemetery Association Conference in Dallas.

Clay Stalnaker, Dept. of Religious Studies, North Carolina State University. Founder of the Group on Thanatology of the American Academy of Religion and editor of Thana-Topics.

Hal W. French, Dept. of Religious Studies, Univ. of South Carolina. Has taught course, Awakening to Death, at USC since 1976. Presented paper in England this spring on current funeral practices in America.

Other University personnel, including Father Steven Lynch, Roman Catholic Chaplain, and Dr. David Fredrick, College of Education, President of the national Forum on Death Education and Counseling.

SPONSORS: The Department of Religious Studies, USC and the USC Campus Chaplains, with the cooperation of the Columbia Ministerial Association and the Lutheran Southern Seminary.

The Workshop is partially funded by a grant from the South Carolina Committee for the Humanities.

Registration and Dinner Reservations for the Workshop on THE CHURCH AND THE FUNERAL

Return to Dr. Hal W. French, Dept. of Religious Studies, University of South Carolina, Columbia, S.C. 29208. Mail reservations must be received by Tuesday, October 20. Phone reservations may be made till noon of October 20 at 777-4100. Checks should be made payable to The University of South Carolina.

Number of dinner reservations ($4.75) and registrations ($1.25) _____

($6.00 total per person)

Payment enclosed_____ Will pay at door _____

Names: Addresses:

Workshop Schedule: THE CHURCH AND THE FUNERAL

1:00 Registration

1:30 Afternoon session begins. Dr. Kevin Lewis, USC, Presiding. "The Contemporary British Funeral" Eric Spencer.

2:30 Filmstrip- "A Time to Mourn, a Time to Choose"

2:45 "Signs of a Thanatocracy? A Study of Current American Funeral Practices" Hal W. French

3:45 Break

4:00 Filmstrip- "Dealing with Loss and Grief"

4:15 "Grief Counseling" Clay Stalnaker

5:15 Discussion Groups

6:15 Dinner - Catered by The Lizard's Thicket.

7:30 Panel, "The Church and the Funeral", Pastor David Donges, presiding Participants: Mr. Spencer, Mr. Field, Dr. Stalnaker, Dr. French, Dr. Fredrick, Father Lynch, Rev. Robert Riegel.

9:00 Concluding observations and directions.

7:30 Breakfast meeting with workshop leaders and interested parties- place to be determined.

A Workshop on

THE CHURCH AND THE FUNERAL

Washington Street Methodist Church
Columbia, South Carolina

Friday, October 23
1981

Co-sponsored by The Dept. of Religious Studies, University of South Carolina and the USC Campus Chaplains, with the cooperation of The Columbia Ministerial Association and the Lutheran Southern Seminary.

Partially funded by a grant from the South Carolina Committe for the Humanities.

Dept. of Religious Studies
University of South Carolina
Columbia, S.C. 29208

Claude R. Vaughn, Chairman
Legislative Forum
S. C. Federation of Older Americans (SCFOA)
P. O. Box 12344
Columbia, SC 29211

Members of the Legislative Forum of the South Carolina Federation of Older Americans have assisted members of the Study Committee on Aging for the past three years in seeking legislation on:

1. Proposed Changes in the South Carolina Probate Code
2. Natural Death Act.

In addition to these two items, the members of the SCFOA ask the Committee to focus their attention to the following:

1. Maintenance of the integrity of the Social Security System.
2. Keep up present progress of health care for the elderly.
3. Improve transportation system.
4. Treatment of State retirees compared to State employees.
   Since this was written, Mr. Larry Ellis, Executive Director, S. C. State Employees Association, has spoken to their membership on this subject and allayed some of their fears. Also, an invitation has been extended to Mr. Purvis Collins, Director, S. C. Retirement System, who will speak on this issue at their next meeting.

In closing, Mr. Vaughn expressed the appreciation of the Legislative Forum for the splendid work this Committee is doing for the older citizens of South Carolina and asked for support on the above-mentioned items.

(Mr. Vaughn's presentation follows).

There were no questions asked of Mr. Vaughn.

SOUTH CAROLINA FEDERATION OF OLDER AMERICANS
P. O. BOX 12344
COLUMBIA, SOUTH CAROLINA 29211

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President

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September 10, 1981

The Honorable Hyman Rubin,
Chairman, SC Joint Study Committee
on Aging,
The State House,
Columbia, SC 29201

Dear Senator Rubin:

Members of the Legislative Forum of the South Carolina Federation of Older Americans have been working, quite diligently, for the past three years in an effort to assist certain members of this Committee and others in seeking legislation on the following:

(1) Proposed Changes in the South Carolina Probate Code.

(2) Natural Death Act - Death With Dignity.

The issues of the two items of legislation have been presented in several ways, such as forums, public hearings, informal discussions, written and telephonic communications, in an effort to show the support of the Senior Community. Therefore, I will not take your time today to present these issues again.

In addition to the above, there were several other items of interest discussed at our last meeting, which we feel should merit the attention of this committee as a whole and as individuals. These are (1) maintaining the integrity of the Social Security System in such way that the senior citizens of South Carolina will not suffer undue hardships by having those benefits taken away unjustly. (2) Maintain, at least, the present progress in the Health Care of older citizens, but enhance this program, if it is financially and otherwise possible to do so. (3) Continue to move in the direction of improving the Transportation system for the benefit of all, and more especially the older citizens. (4) It appears, from the discussions of our forum members, that the State Retiree is being treated like a second class citizen in comparison with the State Employee, particularly as it pertains to Cost of Living Adjustments for the retirees. Therefore, it seemed appropriate to us that this Committee should use its influence in "righting this embalance" in that regard. I understand this item will be addressed in more detail by others at this hearing.

I wish to express the appreciation of the Legislative Forum for the splendid work this committee is doing for the older citizens of South Carolina and ask your support of the items contained in this letter.

Sincerely,

CLAUDE R. VAUGHN,
Chairman, Legislative Forum

Dr. Estellene Walker
Columbia, SC

Dr. Walker spoke on the dilemma and problems of the State retiree whose base pension is eroded by inflation. There is a cost-of-living adjustment built into the Retirement System; however, the retiree does not get this adjustment until he/she has been retired for two years. Any increases given should be included in the base pension to provide a continual benefit to meet the inflated cost of living.

Senator Rubin assured Dr. Walker that this Committee will work with Mr. Collins on this matter. However, Mr. Collin's major objective is the financial integrity of the Retirement System and to solve the retirees' problem would take additional State funding. The Legislature is willing and wants to help all it can, and it is difficult to prioritize the various demands. "But you keep working on it; enough support will bring further improvement," the Chairman said.

(Dr. Walker's statement is on the following page).

Legislative Joint Study Committee on Aging

Public Hearing 24 September 1981

Statement of Estellene P. Walker, State Retiree

Mr. Vaughan has given me this opportunity to add a postscript to his remarks. I want to call your attention to the dilemma and the problem of the State Retiree whose base pension is being eroded away by inflation. Although there is a 4% cost of living adjustment built into the Retirement System, the Retiree does not get this adjustment until he has been retired for two years. I can assure you that the spiraling inflation takes no two year holiday but gnaws away at the retiree's pension from the day of retirement.

I believe that the State Retiree and the State Employee should receive the same cost of living adjustment. Both live in the same world and encounter the same degree of inflation. Where the State Employee with a 7% cost of living increase is also eligible for a 3.5% merit increase or a 5% longevity increase and may also be reclassified into a higher grade with the commenserate salary, the State Retiree is locked into the base pension he received upon retirement. His one recourse is the Legislature which could add to the 4% built into the system the additional funds needed to bring the total to the same percentage received by the State Employee. Any increase given should be included in the base pension to provide a continual benefit to meet the inflated cost of living. This year a 2% bonus will be provided retirees on the 1st of November -- a "once" only payment which should be made a continuing benefit and added to the base pension.

State Retirees appreciate the fine retirement system we have and are grateful to the help of the legislature in meeting health insurance costs. We believe that you would want to know the problems we are having and will want to do something about it. After all, if you are lucky you will be a State Retiree yourself someday and it is only common sense to anticipate and solve as many problems as possible while you still have the power to do so.

Mrs. Gilroye A. (Rachel) Griffin
Nutrition Site Manager
Richland-Lexington Council on Aging

Mrs. Griffin spoke of the basic and psychological needs of the elderly. She urged the Committee to do all it can for their welfare in these areas.

In closing she read a poem which follows her written statement on the next pages.

Senator Rubin thanked Mrs. Griffin for her presentation and for the "encouraging final note." He told her that we have a lot of problems but we do recognize them and address ourselves to them. "The older years should be the golden years, and that is what we are striving for."

Dr. Parrish added that Mrs. Griffin is the site manager in his church. He felt that often in the pursuit and carrying out of our duties, we become so professional that we lose sight of what we really talk about. This is why he asked Mrs. Griffin to come today and "tell it just like it is. And that is what Mrs. Griffin did. Thank you."

Senator Rubin added that this is a very "human type" Committee and is very concerned and trying to do the best it can at the given time.

PUBLIC HEARING

Sponsored By

The Study Committee On Aging

Subject: <u>The Problems of South Carolina's Older Citizens</u>

Testimony presented by Mrs. G. A. Griffin:

Greetings.

In order to identify the needs and concerns of older citizens, I shall speak briefly from the list below which includes some of their psychological as well as basic needs.

1. Older citizens need to feel assured of
   a. Food
   b. Clothing
   c. Shelter
   d. A sense of worth
   e. Love
   f. Hope
   g. Independence
   h. Usefulness

2. Older citizens need to feel assured of protection from
   a. The criminal element in our society
   b. Family members who abuse them
   c. Those who would exploit them

3. Older citizens need to feel assured of adequate health care
   a. At home
   b. In the hospital
   c. In the nursing home

Rachel C. Griffin

Submitted by: Mrs. G. A. Griffin

How do I know my youth is spent?
Well my get-up-and-go has got up and went.
But in spite of it all I am able to grin
When I think of the places my get-up has been.

Old age is golden, so I've heard it said,
But sometimes I wonder, when I get in bed--
With ears in a drawer, my teeth in a cup,
My eyes on the table until I wake up.

Ere sleep dims my eyes, I say to myself,
"Is there anything else I should lay on the shelf?"
But I'm happy to say as I close my door,
My friends are the same people, even more.

Now when I was young my slippers were red,
And I could kick my heels clear over my head.
When I grew older my slippers were blue,
But still I could dance the whole night "through."

Now I am old and my slippers are black,
I walk to the stove and puff my way back.
Thereason I know my youth is all spent,
My get-up-and-go has got up and went.

But really I don't mind when I think with a grin,
Of all the grand places my get-up has been.
Since I've retired from life's competition,
I busy myself with complete repetition.

I get up each morning and dust off my wits,
Pick up the paper and read the "Obits."
If my name isn't there, I know I'm not dead,
So, I eat a good breakfast and go back to bed.

Mr. W. J. Castine, Chairman
Joint Legislative Committee
NRTA-AARP

This presentation was based on what the members of the NRTA-AARP believe to be the most pressing concerns of senior citizens. It was developed after considerable input from the membership through survey questionnaires.

Their priority issues are:

1. Reform the S. C. Probate Code.
2. Correct discrimination of elderly persons using Medicare/Medicaid for payment.
3. Continue cost-of-living increase of at least 4 percent through Appropriation Bill.
4. Adopt minimum standards regarding condominium conversion.
5. Expand homemaker/health aide services and other community programs to prevent unnecessary institutionalization.

They support the following issues:

1. Consumer representation on licensure and regulatory boards and commissions.
2. Improve transportation needs of the elderly.
3. Support passage of the S. C. Natural Death Act.
4. Provide proper training to persons delivering health services.
5. Institute measures to control rising crime rates and establish a victim restitution program.

(Mr. Castine's presentation is on the following pages).

Senator Rubin thanked Mr. Castine for his statesman like presentation in which he held himself to the realities of what might be possible and fortunately we have made progress in a number of these areas already thanks to the assistance of Mr. Castine and his associates.

THE JOINT STATE LEGISLATIVE COMMITTEE, NRTA-AARP

Statement to The Legislative Study Committee
on Aging, September 24, 1981

Mr. Chairman and members of the committee I am W. J. Castine, chairman of the Joint State Legislative Committee, NRTA-AARP. These two associations have a combined membership of about 90,000. We are interested in the health and welfare of all older persons in South Carolina, and the legislative program which I am presenting to you this morning is based on what we believe to be the most pressing concerns of the aging.

This program was developed after receiving considerable in-put from our members through survey questionnaires. The committee has selected five priorities and five support issues, after careful study and much discussion.

Priority Issues:

1. Reform the South Carolina Probate Code, establishing a process for probating estates with savings of time and costs.

Our organizations support this legislation very strongly, and hope to see it passed in 1982.

2. Assure elderly persons access to and service by state-licensed health care providers and facilities, without discrimination based on method of payment.

When an elderly person in need of health care or medical attention is turned away because he must rely on Medicaid or Medicare to meet the costs, he may suffer unnecessarily. We urge further study to determine what steps can be or should be taken to correct this situation.

3. Continue cost-of-living increase for state retirees of at least 4 per cent to be provided through the general appropriations bill.

Inflation continues to be a major threat to the buying power of persons living on a fixed income. Retirees find it more and more difficult to maintain the standard of living to which they have become accustomed. With four per cent increase from the retirement system, and another four per cent from general appropriations, retirees will still be well below the rate of inflation.

4. Adopt minimum standards for conversion of rental units into condominiums, to provide elderly occupants with first option to purchase, adequate time and appropriate assistance in locating new accommodations as basic elements.

This is a serious threat or problem to many elderly who have made their homes in rental units for years. They are unable to purchase such a unit, many prefer not to, and many are being forced to move out on too short notice. We urge further study and action in this matter. We support legislation introduced on March 5, 1981, in both House and Senate.

5. Expand homemaker/health aide services and other community programs to prevent premature and/or unnecessary institutionalization, including funding for the Tri-County Long Term Care Project.

According to latest reports, medical care costs are still rising faster than the rate of inflation. It is essential that every effort be made to provide as much and as good health service in the home as possible, so that the elderly patient is not forced to enter an institution. Furthermore, in general, the patients are happier and better off in their homes if adequate care can be provided.

Support Issues

1. Place consumer representatives on licensure and regulatory boards and commissions.

We are glad that some progress is being made in this area. We shall continue to work for consumer representation on other boards and commissions.

2. Increase state attention to and appropriations for transportation needs of the elderly.

This is a difficult problem, and the solution is not easy. We urge continuous effort to find the right solution.

3. Support passage of the "South Carolina Natural Death Act."

We believe this legislation should be enacted into law. There are too many cases of prolonged suffering and agony of elderly patients who are terminally ill. We urge the legislature to act favorable on this bill.

4. Improve the quality of health care by increasing state efforts to properly train and certify persons providing services to the elderly in hospitals, nursing homes, and long term care facilities.

Frequently, we hear reports of health services being provided by persons without proper training. This can have serious consequences. We urge that steps be taken to make sure that health services are always provided by persons qualified to give such services.

5. Support measures to decrease/control rising crime rates. including establishment of victim restitution programs and the promotion of "citizen watch" type programs.

With the high crime rate today and so many crimes being committed against elderly persons, it is imperative that further action be taken to bring it under control.

This committee is aware of many other issues and proposals that would benefit elderly persons. We will cooperate with other groups, organizations, and individuals in pursuing legislation in behalf of all elderly persons in South Carolina.

Thank you for this opportunity to speak. And on behalf of all NRTA and AARP members in South Carolina, let me express our gratitude and appreciation for the work of the Legislative Study Committee.

Mrs. Betty Coleman
Advisory Committee Member
Lower Savannah Regional Aging Advisory Committee

Mrs. Coleman's presentation addressed the in-home care of the elderly and pointed out that between 20 to 25 percent of institutionalized older persons presently in nursing homes could live in the community if appropriate support services were available. Further, she remarked on the high cost of nursing home care which absorbs public and private funds and is an inefficient use of this service. She cited the profound impact of Medicaid's nursing home coverage on its budget, and while only 5 percent of all Medicaid recipients are in nursing homes, its high costs make it the service requiring the largest expenditures. Home health care is available, but due to restrictive guidelines the infirm elderly are not always the recipients of this service. Some frail elderlies may need only basic support in order to stay at home; however, this is not reimbursable under the Medicaid guidelines.

Title XX programs provide a limited number of in-home services, and Title III programs pick up as much as possible; however, there is still a growing need for in-home services that can be provided outside categorical programs. Mrs. Coleman thinks that the State Block Grant approach may be the answer to meet the needs of these homebound persons.

She suggested the following:

1. Coordinate services--existing programs are fragmented. Services for the infirm elderly could be located in one agency, such as a Council on Aging.

2. The focus of Medicaid and Medicare should be redirected and provide preventive care and services, thus avoiding costlier acute crisis care.

3. There should be a follow up on priority setting to channel shrinking resources into programs which have the greatest impact on the neediest clients.

In closing, she urged the Committee to consider expanding in-home services through the Councils on Aging to those elderly who must rely on services available in the community.

(Complete statement is on the following pages).

Senator Rubin assured Mrs. Coleman that we are working along those lines and that her reemphasis is appreciated.

TESTIMONY BEFORE THE STUDY COMMITTEE ON AGING

PUBLIC HEARING - SEPTEMBER 24, 1981

By Betty Coleman
Advisory Committee Member
Lower Savannah Regional Aging Advisory Committee

EVERY CULTURE SEEMS TO HAVE WITHIN ITS FOLKLORE A VARIATION OF THE STORY OF THE AGING PARENT WHO LAMENTS: "HOW CAN ONE MOTHER TAKE CARE OF TEN CHILDREN BUT TEN CHILDREN CAN'T TAKE OF ONE MOTHER?"

DATA EMERGING FROM A NUMBER OF RECENT STUDIES DO NOT SUPPORT THIS HOMELY ASSESSMENT OF INTERGENERATIONAL RECIPROCITY. RATHER, STUDIES HAVE SHOWN THAT AN OVERWHELMING MAJORITY OF ADULT CHILDREN DO "CARE FOR AND ABOUT" THEIR AGED PARENTS. IN DESIGNING PLANS TO SERVE THE ELDERLY, IT IS VITAL TO RECOGNIZE THAT PARTICIPATION IN KINSHIP NETWORKS VARIES GREATLY AMONG THE FRAIL ELDERLY. WHEREAS, ONE OLDER PERSON MAY HAVE A NUMBER OF SIBLINGS, OFFSPRING, OR LONG-TIME NEIGHBORS AND FRIENDS: ANOTHER MAY BE THE LAST SURVIVOR, ONE WHOSE SPOUSE, RELATIVES AND FRIENDS HAVE PRECEDED THEM IN DEATH. THE NEED FOR SERVICES FOR A FRAIL PERSON IS LIKELY TO BECOME ACUTE UPON THE DEATH OR ILLNESS OF A SPOUSE OR UPON THE INABILITY OF A RELATIVE TO CONTINUE TO OFFER SERVICES INFORMALLY.

WHAT ABOUT THOSE PERSONS WITHOUT FAMILIES, OR WITH FAMILIES WHO CANNOT OR WILL NOT PROVIDE A HOME AND CARE? WHAT ABOUT THAT LARGE PERCENTAGE OF ELDERLY WHO DESPERATELY PREFER TO REMAIN INDEPENDENT AND IN THEIR OWN HOME?

IN TODAY'S MOBILE SOCIETY, MANY CHILDREN LIVE GREAT DISTANCES FROM THEIR PARENTS AND HAVE CHOSEN TO DEVELOP THEIR OWN CAREERS AND LIFE STYLES. PARENTS OFTEN DO NOT WANT TO MOVE TO THEIR CHILDREN'S NEW

LOCATION AND THE CHILDREN DO NOT WANT TO RETURN TO THEIR HOMETOWN. ADDITIONALLY, MANY ADULT CHILDREN UPON WHOM OLDER PARENTS MIGHT DEPEND FOR SUPPORTIVE SERVICES ARE THEMSELVES IN THE RETIREMENT YEARS AND OFTEN WITH LIMITED ENERGY AND FINANCIAL RESOURCES TO PROVIDE IN-HOME CARE EVEN THOUGH MINIMAL CARE AND SUPPORTIVE SERVICE IN THE HOME IS FAR LESS EXPENSIVE THAN CARE IN A NURSING HOME.

THERE IS, OF COURSE, A POINT WHERE IN-HOME CARE BECOMES MORE EXPENSIVE THAN CARE IN AN INSTITUTION, BUT THAT DOES NOT OCCUR UNTIL THE PATIENT IS EXTREMELY OR GREATLY IMPAIRED AND NEEDS 24-HOUR NURSING CARE AND SUPERVISION. BETWEEN 20-25% OF THE INSTITUTIONALIZED OLDER PERSONS PRESENTLY IN NURSING HOMES COULD LIVE IN THE COMMUNITY IF APPROPRIATE SUPPORT SERVICES WERE AVAILABLE. PLACING ELDERLY PERSONS IN NURSING HOMES WHEN THEY HAVE THE POTENTIAL TO REMAIN IN THE COMMUNITY IS PROBLEMATIC BECAUSE:

1. IT IS CONTRARY TO THE WISHES OF MOST ELDERLY AND THEIR FAMILIES. THE MAJORITY OF ELDERLY INDIVIDUALS OWN THEIR OWN HOMES. SOME ARE ADEQUATE AND SOME ARE INADEQUATE DWELLINGS, BUT THE FACT REMAINS THAT THE OLDER PERSONS SIMPLY DO NOT WANT TO LEAVE THEIR OWN LIVING QUARTERS.
2. NURSING HOMES ARE, AS A MATTER OF NECESSITY, REQUIRED TO PROVIDE A MORE INTENSIVE LEVEL OF CARE THAN IS ACTUALLY NEEDED FOR SOME PERSONS, AT A FAR GREATER COST THAN THAT SAME SERVICE COULD BE PROVIDED IN THE HOME SETTING.
3. NURSING HOME CARE ABSORBS A COSTLY OUTLAY OF PUBLIC AND PRIVATE FUNDS AND IS AN INEFFICIENT USE OF THIS SERVICE. IT IS DOCUMENTED THAT PUBLIC AGENCIES SPEND FEWER DOLLARS PER PERSON FOR IN-HOME CARE THAN ARE SPENT FOR INSTITUTIONAL CARE.

THE IMPACT OF MEDICAID'S NURSING HOME COVERAGE ON ITS BUDGET HAS BEEN PROFOUND. WHILE ONLY 5% OF ALL MEDICAID RECIPIENTS ARE IN NURSING HOMES, ITS HIGH COSTS MAKE IT THE SERVICE REQUIRING THE LARGEST EXPENDITURES. MEDICAID'S ROLE IN FINANCING NURSING HOME SERVICES NATIONALLY HAS A SIGNIFICANT EFFECT UPON THE MEDICAID BUDGET. PLAN AFTER PLAN HAS SUGGESTED STRATEGIES AND STEPS THAT NEED TO BE TAKEN IN ORDER TO MAKE IT POSSIBLE TO PROVIDE ADEQUATE COMMUNITY BASED SUPPORT (IN-HOME SERVICES) THAT ENABLE ELDERLY INDIVIDUALS TO REMAIN IN THEIR OWN HOMES AND COMMUNITIES. HOME HEALTH CARE IS AVAILABLE BUT THE INFIRM ELDERLY ARE NOT ALWAYS RECIPIENTS OF THIS SERVICE BECAUSE OF RESTRICTIVE GUIDELINES. TO BE ELIGIBLE FOR HOME HEALTH CARE, A PERSON MUST BE CONFINED TO HIS OR HER RESIDENCE, BE UNDER THE CARE OF A PHYSICIAN AND NEED PART-TIME OR INTERMITTENT SKILLED NURSING SERVICES AND FURTHER, A PHYSICIAN MUST PRESCRIBE THE NEED FOR SUCH CARE.

IN MANY CASES, AFTER SKILLED NURSING CARE IS NO LONGER NEEDED, THE FRAIL ELDERLY PERSON STILL REQUIRES SUPPORTIVE SERVICES NOT INCLUDED UNDER THE DEFINITION OF HOME HEALTH CARE. SUCH SERVICES INCLUDE HOMEMAKER, HANDYMAN, COMPANIONSHIP, HOME DELIVERED MEALS, OR LIKE SERVICES PROVIDED INSIDE THE HOME, BUT THESE SERVICES ARE NOT REIMBURSEABLE UNDER HOME HEALTH CARE AND MEDICAID GUIDELINES WITHOUT THE PROVISION OF SKILLED NURSING CARE. THE FRAIL ELDERLY PERSON MAY NEED ONLY BASIC SUPPORT TO REMAIN INDEPENDENT AND IN HIS OWN HOME, BUT IF THOSE SUPPORT SERVICES ARE NOT AVAILABLE, THE ONLY PLACE TO TURN IS TO THE NURSING HOME.

EVERYONE KNOWS THAT FUNDS ARE LIMITED. HOWEVER, THE NUMBER OF ELDERLY IN THE NATION AND IN SOUTH CAROLINA IS INCREASING. PARTICULARLY GROWING IN NUMBERS ARE THE "OLD-OLD" (THOSE OVER 80). THERE WILL BE,

THEREFORE, A GREATER DEMAND FOR THE DOLLARS AVAILABLE. WOULDN'T IT BE A MUCH MORE EFFICIENT USE OF THOSE DOLLARS IF THEY ~~WERE~~ PROVIDED FOR INCREASED IN-HOME SUPPORT SERVICES. COSTLY INSTITUTIONALIZATION COULD BE PREVENTED OR DELAYED, MORE PEOPLE WOULD BE SERVED, AND ELDERLY PREFERENCES WOULD BE MET.

TITLE XX PROGRAMS PROVIDE A LIMITED NUMBER OF IN-HOME SERVICES: TITLE III PROGRAMS PICK UP AS MUCH OF THE SLACK AS POSSIBLE, BUT THERE STILL IS A GROWING NEED FOR IN-HOME SERVICES THAT CAN BE PROVIDED OUTSIDE CATEGORICAL PROGRAMS. THE STATE BLOCK GRANT APPROACH MAY BE THE ANSWER TO THIS PROBLEM. FUNDS COULD BE FILTERED TO LOCAL AGING PROGRAMS TO PICK UP THE SLACK IN TITLE XX AND TITLE III PROGRAMS AND SERVE THOSE PERSONS WHO ARE NOT ABLE TO RECEIVE IN-HOME SERVICES BECAUSE THEY DO NOT FIT THE DEFINITION OF HOME HEALTH SERVICES THAT ARE REIMBURSABLE UNDER MEDICARE OR MEDICAID.

THE BLOCK GRANT PROGRAM PRESENTLY BEING PROPOSED BY CONGRESS, A PROGRAM WHICH WILL IN ALL LIKELIHOOD BECOME A REALITY, IS THE APPROACH TO USE IN ORDER TO MEET THE NEEDS OF THESE HOMEBOUND PERSONS.

IN MARCH, 1979, THE LOWER SAVANNAH COUNCIL OF GOVERNMENTS, UNDER CONTRACT WITH THE DEPARTMENT OF SOCIAL SERVICES, SPONSORED SUBREGIONAL PROGRAMS CALLED THINKTIMES. OUT OF THESE SESSIONS CAME AN ACTION PLAN OF SUGGESTED STRATEGIES AND STEPS THAT NEEDED TO BE TAKEN IN ORDER TO MAKE IT POSSIBLE TO PROVIDE ADEQUATE COMMUNITY-BASED SUPPORT TO INFIRM ELDERLY INDIVIDUALS TO ENABLE THEM TO REMAIN IN THEIR OWN HOMES AND COMMUNITIES. PARTS OF THIS PLAN ARE STILL VERY APPLICABLE TODAY AND COULD BE AN EFFECTIVE APPROACH TO MEETING THE NEEDS OF SOUTH CAROLINA'S HOMEBOUND THROUGH THE BLOCK GRANT PROGRAM.

FIRST OF ALL, EXISTING PROGRAMS ARE FRAGMENTED. COORDINATION OF SERVICES COULD PROVIDE A CONTINUUM OF GOOD QUALITY SERVICES FROM WHICH APPROPRIATE ONES COULD BE SELECTED FOR A CLIENT REGARDLESS OF WHICH AGENCY PROVIDES THEM. SERVICES FOR THE INFIRM ELDERLY COULD BE LOCATED IN ONE AGENCY, SUCH AS A COUNCIL ON AGING, OF WHICH THERE IS ALREADY A STRONG BASE IN SOUTH CAROLINA.

SECONDLY, THE FOCUS OF MEDICAID AND MEDICARE SHOULD BE REDIRECTED TO ALLOW PREVENTIVE MAINTENANCE CARE AND SERVICES TO AVOID COSTLIER MORE THREATENING ACUTE CRISIS CARE.

FINALLY, THERE SHOULD BE A FOLLOW-UP ON PRIORITY SETTING TO CHANNEL SHRINKING RESOURCES INTO PROGRAMS MOST NEEDED, THOSE HAVING THE GREATEST IMPACT ON NEEDIEST CLIENTS. THIS WOULD HELP DETERMINE THE SERVICES WHICH ADDRESS SUCCESSFULLY PROBLEMS AND GOALS AND WOULD BE THE MOST EFFICIENT USE OF AVAILABLE FUNDS.

ONLY THROUGH A STRONG HOME-BASED PROGRAM WILL THE ELDERLY BE ABLE TO REMAIN IN THEIR OWN HOMES. WHAT BETTER USE OF TAX DOLLARS IN SOUTH CAROLINA THROUGH THE BLOCK GRANT APPROACH THAN FOR AN EMPHASIS ON THE ELDERLY POPULATION? WHAT BETTER OPPORTUNITY DO WE HAVE TO CARE FOR THOSE IN THIS STATE WHO HAVE REACHED THE RETIREMENT YEARS, A LARGE PERCENTAGE OF WHOM HAVE LIVED IN THIS STATE ALL OF THEIR LIVES AND HAVE CONTRIBUTED TO ITS RESOURCES AND TO ITS GROWTH. WE MUST NOT FORGET THEM NOW AND SIMPLY SAY TITLE XX, TITLE III, TITLE XIX, WILL TAKE CARE OF THEM BECAUSE IT WILL NOT. MORE STATE DOLLARS WITH FEWER RESTRICTIONS ARE NEEDED TO GO INTO THESE PROGRAMS IF WE ARE TO MEET THE RISING INCREASE IN THOSE ELDERLY WHO MUST RECEIVE CARE. NURSING HOME BEDS ARE CRITICALLY IN SHORT SUPPLY AND MORE AND MORE ELDERLY REMAIN IN THEIR OWN HOME, BECOME MORE ISOLATED AND CONTINUE TO DETERIORATE AND TO DIE

BECAUSE IN-HOME SUPPORT SERVICES ARE NOT AVAILABLE.

ON BEHALF OF SOUTH CAROLINA'S ELDERLY, WE URGE YOU TO CONSIDER EXPANDING IN-HOME SERVICES THROUGH THE COUNCILS ON AGING TO THOSE HOMEBOUND ELDERLY WHO MUST RELY ON SERVICES AVAILABLE IN THE COMMUNITY; AND WHO, WHEN THOSE SERVICES ARE NO LONGER AVAILABLE, HAVE LITTLE ALTERNATIVE BUT TO FACE ISOLATION AND/OR INSTITUTIONALIZATION.

Mr. Harold G. Dye,
Legislative Chairman, Charleston Chapter 267
AARP

Mr. Dye presented three additional needs which he feels should be solved during the coming year.

1. Undertake a more thorough study, along with a more detailed audit, of the hospitals costs and charges, coupled with the authority to control these charges. As an example, he cited a personal experience of a three-week hospital stay this past June.

Some states have established commissions to regulate and hold down these costs, "and it is time that South Carolina look into this." Since we do the licensing of hospitals, we should also exercise the control, he stated.

2. He brought up the subject of monopolies. Nearly every time we require a license to operate, we create a monopoly At the same time, a board or commission is created to regulate the respective professions. There are few objections, when the monopoly created is a large corporation; however, when it is by individuals, we feel no controls are fair or needed, and if any are needed, they should be exercised by unpaid committees of the ones performing the services. These include most performing health care providers, such as, doctors, dentists, as well as other professions. "In the case of the doctors and dentists, we not only give them a strict monopoly, but we also subsidize their education by up to $100,000 per person, if we educate them in our State--all of which is paid for by tax paying citizens."

Some states have started to require that members of all commissions be consumers, with no personal stake in the decisions.

Further, he stated that all doctors should be required to accept patients without discrimination whether they will be paid by Medicare or Medicaid.

3. Coordination between the many groups, organizations, boards, commissions and committees working to improve the care for the elderly. He suggested that the Commission on Aging take the initiative in this effort.

(Mrs. Dye's presentation is on the following pages).

Senator Rubin thanked Mr. Dye and reassured him that we are doing our best to coordinate these efforts and some progress is being made.

To: S,C. Study Committee on Aging - Public Hearing Sept. 24, 1981.

From: Harold G. Dye, A Concerned Citizen,
Legislative Chairman Charleston Chapter #267, A.A.R.P.
S.C. Delegate to 1981 White House Conference on Aging.

Subject: Three suggestions for Action by Committee in 1981-1982.

Members of the S.C. Study Committee on Aging, and Ladies and Gentlemen, I thank you for this opportunity to speak to you today, and to express my views on these problems. First, I want to congratulate this Committee, and in particular your Director of Research and Administration, Ms. Keller Bumgardner, on your excellent 1981 Report on the Public & Private Services, Programs and Facilities for the Aging, which you published in July of this year. It is a mostcomplete, but concise, study of what has been proposed, what is being implemented, what our legislature is doing, and the current status of the many, many proposals for assisting the elderly of this state. I do not intend to repeat any of these proposals today, but do wish to suggest to this committee three additional needs, with suggested solutions, that something should be done about during this coming year.

First, a more thoro study, along with a more detailed audit of the hospitalc costs and charges (with comparison between differing hospitals of those charges), coupled with the authority to do something to control these costs and charges. From my personal experience this past June, when I spent some three weeks in one of the Charleston hospitals, the bill for the care I received there was quite disturbing. While my Medicare and Medigap insurance took care of the full amount, I realized that any of these bills over and above the premiums I paid was being paid by tax dollars, or in the case of the Medigap insurance by other policy holders. The daily room charge I did not think to be excessive, especially in comparison to room charges today in the better motels and hotels. But this charge was greatly exceeded by the other charges. These came to 200% to 500% over similar charges I had to pay only 5 years before in a similar hospital stay. There was a big increase both in amount and percentage wise in the charges made in the use of the operating room, for the anesthesia itself, for the so called medical and surgical supplies, for the drugs used (checking with local pharmecies on the outside after I was released, they were 20 times higher than I could have purchased them myself), laboratory fees, the X-Rays taken (twice what I paid for similar ones taken just two weeks earlier as an out-patient), and for a very large so called miscellaneous charge. Some states have established commissions to regulate and to hold down these costs, and it is time South Carolina looked into it. Some are urging this be done on a Federal level, but we do the licensing of all the Hospitals, so we should also exercise the controls.

Second, I would ask that all of you stop and think a lot about the question of monoplies. We have a lot of them in this state, nearly every time we require a license

to operate, we create at the same time a monopoly. For some we at the same time set up a board or a commission to regulate them, to see that they give good service, that they are careful to protect the public and the customers, and that their charges are fair, while allowing for a reasonable profit for their costs and investment risks. We have few objections for all this - when the monopoly created is a large corporation, such as the telephone company, the gas and electric utilities. firms furnishing some areas with water or sewer services. However, when the monopoly is by individuals, we are prone to feel no such controls are fair or needed - that any needed, should be exercised by unpaid committees of the ones performing the services. These include most performing health care such as physicians, dentists, etc., our plumbers and the electricians, barbers and beauty parlor operators and others. In the case of the medical doctors and the dentists, we not only give them a strict monopoly, but if we educate them in our state, as most are, we subsidize that education by up to $100,000 per person - all of which we tax paying citizens are paying for.

At such a cost, and then giving them a monopoly to practice their trade in our state, we then exercise no control over how well they keep up with changes in the practice of their profession, how well they perform in that profession, or what they charge to their customers for their service. We don't even require them to accept those of limited income, which we the tax payers are paying the shot thru Medicaid or the social services. We give the right to censure, to withdraw their licenses, to others in their profession,peers who may be personal friends, who may well say to themselves "I better go easy, someday I may be accused of the same charges". In some states they have awakened, and require that the majority of all such committees must be consumers, with no personal stake in the decisions. We need to get rid of poorly performing professionals, We need to require all our doctors to accept, without discrimination, patients, without regard as to whether they will be paid by Medicaid or Medicare. We probably should exercise some control over amounts charged patients, but it should be fairly arrived at, and reflecting inflation, increased costs of the purveyor. Medicare tries to do it, but the job they do tends to be lacking in speed of change during the rapid inflation rate we have been having in recent years. The state of South Carolina can change and correct this, and it is past time for it to start. Sacred cows in our Health Care should be eliminated in our state, for the good of not only the elderly, but all of it's citizens.

Third, here in South Carolina we have a multiplicity of groups, organizations, boards, commissions, committees, etc., all interested and working to improve the care and the conditions in which it's elderly are living. Each are staffed by dedicated professional or volunteers, but despite their efforts so much remains to be done. Any study by experts in the fields of management or efficiency, would probably agree that up to 50%

more might be accomplished, with the same number of workers, and the same amount of funds, if there were a maximum amount of cooperation between groups to avoid all duplication, and a maximum amount of coordination to make sure each was doing what they could do best and easiest. Many groups are just duplicating the work of others, through not knowing what the others have and are doing. Many groups could handle a much larger load in certain fields or areas of endeavor, but have no information as how to secure or attract that increase. There are always many organizations (as churches and civic clubs) who would be glad to help, but are not asked, and don't know how or where to start. It is past time that we did more about all this, that we make a determined effort to correlate all these many groups, units, committees, and commissions to working much more closely together. Someone has to take the initiative in doing this, and perhaps the logical one is the S.C. Commission on Aging. If this coming year they were directed to make it a top priority to effect an united effort of cooperation; and with representatives of each of these groups, work out how to coordinate the work and efforts of all groups - each in their own particular sphere or expertise - towards the same broad goals of more fully meeting the varied needs of the elderly of our state, we would see much accomplished. Isn't 1981-1982 the year to start this?

I thank all of you for your kind attention, and for giving me the opportunity to express my views. I urge your careful consideration of each of these three points.

Ms. Susan C. Wrigley, Director
Respite House
Columbia Housing Authority

Ms. Wrigley is a Registered Nurse and the Director of the Respite House, a division of the Housing Authority of the City of Columbia. They provide day care services for physically handicapped adults in the Columbia area and are funded from the Special Services for Handicapped and Disabled Adults Program of Title XX. They were opened by Family Service Center in November of 1975 and then transferred under the jurisdiction of the Columbia Housing Authority in July of 1977. A staff of three is presently serving 59 clients, two thirds of them 60 years of age and older.

Their program provides a variety of services and the benefits of their type of program can best be demonstrated in the story of one of their clients, which Ms. Wrigley related to the Committee. Three factors made it possible for the Respite House to meet this client's needs:

1. The service was free of charge, even though the client/day cost was approximately $28.

2. Transportation was available, especially important for somebody confined to a wheelchair.

3. Adequate staffing to meet the needs. However, since then, staffing has been cut by 25 percent.

Senator McLeod wanted to know the full funding sources.

Mrs. Wrigley explained that the Housing Authority matches $1 for every $3 from Title XX.

Senator Rubin asked if they serve the whole community.

Mrs. Wrigley confirmed that they serve the Columbia community and not just the Housing Authority residents.

(Complete statement on the following pages. An article entitled Adult Day Health Care and the Bottom Line from Geriatric Nursing, July/August 1981, is on file in the Committee).

I am Susan Wrigley, a registered nurse and the Director of Respite House, a division of the Housing Authority of the City of Columbia. Respite House provides day care services for physically handicapped adults in the Columbia area with funding from the Special Services for Handicapped and Disabled Adults Program of Title XX. This facility was opened by Family Service Center in November of 1975 and was transferred to the auspices of the Columbia Housing Authority in July of 1977. Including myself, there is a staff of three presently serving fifty-nine clients. Two thirds of these are age 60 or older. Currently individual clients attend Respite House from one to three times per week.

The services provided include transportation to and from Respite House on our van equipped with a wheelchair lift, evaluation by a consulting physical therapist, assistance with follow through of the exercise program recommended by the physical therapist, monitoring of blood pressure and weight, referral to other agencies or services, and instruction in nutrition and other good health habits.

We provide a variety of activities and experiences in an effort to assist impaired adults to maintain or regain their functional independence.. Some of these activities may at first appear frivolous to the casual observer. A closer look at games, handcrafts, singing and other recreational activities reveals the effort and determination these handicapped adults must have to re-learn their concentration and co-ordination skills. From these accomplishments they begin to improve their self image, an important step in rehabilitation.

The horizons of a physically handicapped adult can become very narrow and monotonous. Field trips, movies, and programs given by civic groups and schools can widen their vision and stimulate their intellect.

The benefits of this type of program can best be demonstrated in the story of one of our clients, who I shall call Mrs. F. The social work department at Richland Memorial Hospital contacted me in the spring of this year. Mrs. F. was in the hospital recovering from a stroke. I met with Mrs. F. and the referring social worker in the physical therapy department of the hospital. Mrs. F. was faced with two alternatives after discharge. She could go to a nursing home or she could live with her daughter who worked. She did not want to consider the nursing home, but she knew she could not stay by herself while her daughter worked. I determined that Respite House could provide services for Mrs. F. five days a week. The first full day Mrs. F. was out of the hospital, her daughter stayed home with her. The second day she began attending Respite House. At this time Mrs. F. was confined to a wheelchair and was unable to transfer from the wheelchair to a commode without assistance. Mrs. F. was evaluated by our consulting physical therapist as prescribed by her physician and the Respite House staff assisted her with the recommended exercises. Within two and a half months, Mrs. F. had returned to her own apartment and reduced her attendance at Respite House to three days per week. She is able to ambulate independently with a standard cane. Though still lacking the use of her affected arm, she can manage her own activities of daily living. Respite House remains an important, supporting element in her life.

Three factors made it possible for Respite House to meet Mrs. F.'s needs. First, the service was free of charge for the client, though the client/day cost was approximately twenty-eight dollars. Second, transportation was available. This was especially important since she was confined to a wheelchair. Third, Respite House was adequately staffed by experienced and dedicated individuals. Staffing has since been cut by 25%.

Supporting the desire of handicapped, disabled or frail aged adults to remain in their own homes and communities, programs like Respite House should be available as an alternative to institutionalization.

Mr. Thomas E. Brown, Jr.
Director
Community Long Term Care Project

Mr. Brown's presentation addressed two issues: 1) a progress report of the Community Long Term Care Project since the last time he appeared before the Committee, and 2) an overview of the proposed expansion into the remainder of the State, starting in July of 1982.

The Project was approved in 1978 by the General Assembly. It was established primarily for the State to test a number of new community services and a system of needs assessment for long term care patients for data gathing for State policy development and planning. The primary focus was on those individuals with long term care problems who would qualify for Medicaid and nursing homes. Since then, the Project has also involved other sources of funding which have been mentioned previously today.

Fiscal year 1979-1980 was the preoperational period for the Project. One of the most significant outcomes of this period was the effect of the Project's mandatory preadmission assessment for nursing home admission. When considering only those clients who met the medical criteria--skilled nursing facility or intermediate care facility--for nursing home admission, 18 percent were diverted to existing community services for their long term care. This is important because all of this group was actively seeking nursing home admission.

During the preoperational period and first year of the experimental phase, the Project has developed a Long Term Care Service Management Concept, which includes client assessments and reassessments, service planning, service authorization, case management and utilization review. When used with a mandatory preadmission screening program, this system has been very successful in assisting potential Medicaid nursing home patients to remain in community settings.

State funding for the Project in the amount of $574,000 is included in the Home Health Section of the DHEC budget for FY 1982-1983. It is the same level of funding which the Project received in FY 1981-1982.

The Long Term Care Policy Council is recommending that the Community Long Term Care Service Management System be expanded statewide in FY 1982-1983 for all individuals qualifying for Medicaid benefits in long term care facilities. In addition, the Council recommends implementation of the following State policies:

1. Mandatory preadmission screening for long term care facility admission.
2. Targeting nursing home and community resources based on priority of need for care.
3. Control of costs for community and nursing home services.
4. Reallocation of existing resources to build a Statewide Long Term Care System.

It is estimated that 12,500 Medicaid eligible persons would use the System in FY 1982-1983 and that 2,200 of the clients who either qualify for or are nursing home residents, will be directed to community-based care each year. This means that those persons who most need institutional care will be able to have access to existing long term care beds.

The Council is proposing phasing in the Service Management System during FY 1982-1983 and FY 1983-1984. Projected total cost and State matching funds for each year are $2.8 million and $965.000 and $4.9 million and $1.5 million, respectively. This expansion will show as a separate line item in the FY 1982-1983 Medicaid budget which has been submitted by DSS.

((Mr. Brown's statement is on the following pages. In addition, the following materials are on file in the Committee: "Yes, You Can Go Home Again," (South Carolina's Long Term Care Project), Appalachia Magazine, Juli/August 1981, and two reports on the development of the Project)).

Senator Rubin thanked Mr. Brown for helping us lead the way. He mentioned that the Budget and Control Board has tentatively given the Project an increase which will enable the phasing in of the Project on a statewide basis.

Senator McLeod asked for the amount of the present State funding.

Mr. Brown informed him that the present State funding for the Project is $574,000 and the total budget amounts to about $1,4 million—the difference being the Federal share.

Senator McLeod asked if they are a facility.

Mr. Brown explained that they are not. All of their service money goes to keep people in their own homes.

Senator McLeod then wanted to know the breakdown of the 1,200 people who were served last year.

Mr. Brown answered that this number represents people who either wanted long term care service in their home or wanted to go to a nursing home. Some of them did, in fact, go to a nursing home. The Project does not serve clients in their offices. The only service they provide is the assessment and service planning authorization activity. All other services, such as, personal care, medical day care, home-delivered meals are provided by other organizations on contract with the Long Term Care Project as the normal Medicaid program is arranged. What each individual patient gets is based on what they need, and this is determined through the assessment process and the service planning which is done through the staff of the Long Term Care Project. Some patients would have personal care every day, for example, some only for one day a week. In every case, they try to build the services they provide and pay for around the capability of the family who takes care of this person at home. Most of the people have someone they live with and can assist in their care. In addition, they arrange for home health nursing.

Senator McLeod referred to the 1200 people they had serviced and wanted to know whether people come daily, or how do they break this down.

Mr. Brown replied that the only service they provide is assessment and service planning. Actual services are provided by contract with other agencies. The number of people they serve is continuing to grow from month to month. They would like to operate for about two more years so they will have enough people long enough to determine the impact of the Project.

Dr. Parrish expressed concern about the reliability of the two groups referred to, the experimental and control group. "Are the basic figures in your sample adequate to be conclusive?"

Mr. Brown assured him that they will be at the end of the Project. This is one reason why they need more time to get more numbers in. The people are the same; the randomization occurs after they have determined that they in fact can meet the Project criteria. The groups will

be the same and the numbers will be sufficient as they go forward.

Dr. Parrish compared the figure of 200 and some against 300 in the other group, which is an inequity. He wondered if Mr. Brown can arrive at a conclusive data, based on the size of the sample and the time involved.

Mr. Brown told him that they can. There are ways to control the numbers in each group statistically.

Presentation to the Study Committee on Aging

September 24, 1981

Thomas E. Brown, Jr., Director

Community Long Term Care Project

Senator Rubin and members of the Study Committee on Aging, I would like to report on the progress of the Community Long Term Care Project during its first year of the experimental phase and provide an overview of the proposed phase in statewide of the project's long term care service management system beginning in July, 1982.

The Community Long Term Care Project was initially approved by the General Assembly in 1978 for the purpose of gathering information that the State could use in planning policies and programs for long term care. The project is administered by the Long Term Care Policy Council which was also established under the 1978 authorizing legislation. The members of the Council are the Governor or his designee, the Commissioners of the Department of Social Services, Mental Health, and Health and Environmental Control and the Director of the Committee on Aging. Two specific items of interest were a long term care service management system which involves client assessment, service planning and case management and an array of new community-based services which might meet the rehabilitative and/or maintenance needs of long term care patients in non-institutional settings. The project completed a planning phase in June, 1979 with the submittal for Medicaid waivers to the Health Care Financing Administration, Baltimore.

Fiscal Year 1979-80 was the preoperational period for the project. During this time final negotiations were held between the State and the Health Care Financing Administration for Medicaid waivers. Also, at the local level, the project initiated an assessment, service planning and case management program for individuals seeking long term care services and, specifically, Medicaid sponsored nursing home admission. Beginning in September, 1979 assessment by the project became a prerequisite for admission to nursing homes for Medicaid clients in the three county project area. During 1979-80 over 700 clients were served by the project.

One of the most significant outcomes of the preoperational period was the effect of the project's mandatory preadmission assessment for nursing home admission, service planning and case management program. When considering only those clients who met the medical criteria, i.e., skilled nursing facility (SNF) or intermediate care facility (ICF), for nursing home admission, 18% were diverted to existing community services for their long term care. This is important because all of this group was actively seeking nursing home admission.

Final approval of the Medicaid waivers was received in July, 1980 and the experimental phase of the project began. The differences between the experimental phase and the preoperational phase are twofold. First, with the experimental phase the project began a randomization process to establish control and experimental groups. The purpose for forming the control and experimental groups was to provide a basis for evaluation of 12 research hypotheses adopted by the project. These hypotheses are grouped in three major areas which are: impact of the project services on clients; cost effectiveness; and impact of the project on the use of hospitals and nursing homes. The second major difference between the preoperational phase and the experimental was the initiation of new community-based services which are financed by the Medicaid waivers. When the experimental

phase began, personal care and medical day care were two of these services. Since that time, contracts have been negotiated for expanded home-based therapies, medical social services, respite care, and home delivered meals.

The mandatory preadmission screening program, which was initiated in September, 1979 continued during the experimental phase and over 1500 clients were referred for project admission. Out of that number a total of 1179 were assessed and assigned to either the control or experimental group. As of the end of June, 1981, there were 270 participants in the control group and 281 participants in the experimental group.

The project appears to be having a very positive impact as measured by the number of experimental clients who remain the community for services (64%) as opposed to the number of control group clients in the community (54%). Also, less experimental clients are hospitalized and institutionalized in nursing homes.

An examination of changes in level of care over the first 90 days of project participation showed that more experimental clients changed to a lower level of care. Among experimentals, 24% were certified at a lower level of care after 90 days, compared with 17% of controls. Similar proportions of both groups changed to higher levels of care: 11% of experimentals and 9% of controls. In the experimental group, 64% were at the same level of care as when they entered the project, compared with 74% in the control group.

These present findings provide a preliminary indication of the characteristics of the Community Long Term Care experimental clients, their utilization of expanded services, and the impact of the project on location in which care is provided, i.e., community or institutional settings. More definitive analyses will be conducted when a sufficient number of clients have been participating in the project for periods of 90 days, six months, one year and longer duration. By July, 1982, data from a year of project participation will be available for about 600 experimental and control clients. State funding for the project in the amount of $574,000 is included in the Home Health Section of the Department of Health and Environmental Control budget for FY 82-83. This level of funding is the same which the project received in FY 81-82.

During the preoperational period and first year of the experimental phase, the project has developed a long term care service management concept, which includes client assessments and reassessments, service planning, service authorization, case management and utilization review. When used with a mandatory preadmission screening program, this system has been extremely successful in assisting potential Medicaid nursing home patients to remain in community settings. As mentioned earlier, 18% of the Community Long Term Care clients who met the medical necessity requirements for nursing home admission and who were actively seeking nursing home placement were directed to existing community services for their long term care in FY 79-80.

Based on this experience, the Long Term Care Policy Council is recommending that the Community Long Term Care Service Management System be expanded statewide in FY 82-83 for all individuals qualifying for Medicaid benefits in long term care facilities. In addition to the establishment of this system, the Council is recommending implementation of the following state policies:

1. Mandatory preadmission screening for long term care facility admission,
2. Targeting nursing home and community resources based on priority of need for care,
3. Control of costs for community and nursing home services,
4. Reallocation of existing resources to build a statewide long term care system.

It is estimated that 12,500 Medicaid eligible individuals would use the system in FY 1982-83 and that 2200 of the clients who either qualify for or are nursing home residents, will be directed to community-based care each year as a result of this system. Therefore, those individuals who most need institutional care will be able to access existing long term care beds.

The Council is proposing to phase in the service management system over a two year period - FY 82-83 and FY 83-84. The projected total cost and State matching funds for each year are $2.8 million and $965,000, and $4.9 million and $1.5 million, respectively. The expansion of the project is identified as a separate line item in the FY 82-83 Medicaid budget which has been submitted by the Department of Social Services. Implementation of this system does not involve an expansion of services, but a more targeted approach to the use of current resources. As discussed earlier, more definitive information about the cost and effectiveness of the new waivered services will be available after July, 1982 for further policy planning.

Two alternatives to this system were considered by the Council. One alternative involved maintaining the status quo with regard to institutional and community-based long term care services. The population and workload projections for the State indicate an expanding elderly population and a corresponding increase in the demand for Medicaid-funded long term care services. In 1982, 21,700 Medicaid eligible, disabled adults are estimated to be living in South Carolina. This number increases to 23,700 in 1985. Of this target population, approximately 16,500 are expected to request services in 1982. With this forecase for increased services, maintenance of the status quo seems infeasible.

The second alternative can be labelled the "business as usual" alternative. Under this option the State would continue to respond to increases in the elderly population and in the demand for long term care services with construction of additional nursing homes. By 1985 over 2100 additional nursing home beds would be needed in the State. Based on Medicaid's share of the 10,625 beds currently in use, the additional cost to Medicaid for this alternative would be approximately $77 million over the next four years. Based on these alternatives, the Long Term Care Policy Council feels that the proposed statewide phase-in of the Community Long Term Care Project's service management system is necessary to control costs and to make the best use of State and Federal resources which are available to serve long term care patients in South Carolina.

The members of the Council and I are appreciative of the assistance and support of the Committee in the past and maintain a great deal of optimism about the future of the project and the proposed statewide expansion.

Dr. Ernest A. Finney, Chairman
S. C. Commission on Aging
Columbia, SC

Dr. Finney's remarks addressed the following areas:

1. S. C. Probate Code
2. Long Term Care Project
3. Condominium Conversion
4. Consumer Protection--Landlord tenant relationships
5. "Medically Needy" Program
6. Transportation--Use of school buses for the elderly
7. Adequate funding for Commission on Aging

(Prepared statement on the following pages).

Senator Rubin expressed his appreciation to Dr. Finney and recognized Representative Dill Blackwell, Mrs. Sarah Shuptrine, former Administrative Assistant of the Study Committee on Aging and now with the Governor's Office and Ms. Suzanne Lewis, also with the Governor's Office.

DR. ERNEST FINNEY'S REMARKS

9/24/31

MR. CHAIRMAN AND OTHER MEMBERS OF THE COMMITTEE

ON BEHALF OF THE COMMISSION ON AGING AND THE STATE'S OLDER POPULATION, WE ARE INDEED GRATEFUL FOR THE CONTINUED COMMITMENT OF THIS COMMITTEE. SOME VERY FINE LEGISLATIVE ACCOMPLISHMENTS HAVE BENEFITTED OLDER SOUTH CAROLINIANS AS A RESULT OF YOUR WORK.

CONSIDERABLE WORK BY THE LEGISLATURE HAS BEEN APPLIED TO SEVERAL SIGNIFICANT BILLS. WE ASK THAT THIS COMMITTEE CONTINUE TO PRESS FOR THEIR PASSAGE.

PERHAPS THE OLDEST OF THESE LEGISLATIVE PRIORITIES, THE PROPOSED SOUTH CAROLINA PROBATE CODE HAS CONSUMED MUCH TIME AND EFFORT IN PAST LEGISLATIVE SESSIONS. WE HAVE VIGOROUSLY SUPPORTED THE PROPOSAL THAT WOULD SIMPLIFY ALL ASPECTS OF INHERITANCE, WILLS, AND THE ADMINISTRATION OF ESTATES. WE ARE ENCOURAGED BY THE CURRENT STATUS OF THE PROPOSAL FOR REVISION AND HOPE THAT SUCCESSFUL PASSAGE WILL BE ATTAINED DURING THE COMING LEGISLATIVE SESSION.

WE ASK YOUR SUPPORT TO OBTAIN PASSAGE OF SEVERAL BILLS RELATIVE TO LONG TERM CARE.

THE COMMUNITY LONG TERM CARE PROJECT, WHICH HAS ENABLED MANY ELDERLY PERSONS IN SPARTANBURG, CHEROKEE, AND UNION COUNTIES TO REMAIN IN THEIR OWN HOMES RATHER THAN ENTER NURSING HOMES, SHOULD BE EXPANDED STATEWIDE. THERE IS A GREAT NEED FOR MORE RESPITE CARE, WHICH IS A COMMUNITY SUPPORT SYSTEM THAT PROVIDES FAMILIES SOME RELIEF FROM THE EMOTIONAL STRESS THAT CAN RESULT IN ABUSE OR NEGLECT OF THE DISABLED ELDERLY.

WE HAVE HEARD THE FRUSTRATIONS OF MANY SENIOR CITIZENS CAUGHT IN THE CONDOMINIUM CONVERSION DILEMMA. WE ARE PLEASED WITH THIS COMMITTEE'S EFFORTS IN THIS AREA. PROPOSED LEGISLATION OFFERS A SIGNIFICANT REMEDY TO ELDERLY TENANTS.

EQUALLY SIGNIFICANT, IN TERMS OF CONSUMER PROTECTION, IS HOUSE BILL 2539 WHICH PROPOSES TO STRENGTHEN TENANTS RIGHTS IN LANDLORD-TENANT RELATIONSHIPS. AS THE LAW IS NOW, IF A TENANT IS HURT AS A RESULT OF THE DANGEROUS CONDITIONS OF THE PROPERTY, THE LANDLORD IS NOT RESPONSIBLE FOR THE INJURIES. SOUTH CAROLINA'S ELDERLY POPULATION CONSTITUTES A SIZEABLE PORTION OF ALL TENANTS. WE ASK YOUR SUPPORT ON THEIR BEHALF.

RISING HEALTH CARE COSTS HAVE PLACED A BURDEN ON THOSE WHO ARE NOT IMPOVERISHED. FOR MANY, THIS AWESOME FINANCIAL BURDEN HAS PLACED THEM NEAR OR BELOW THE POVERTY LEVEL.

WE URGE YOUR SUPPORT IN ESTABLISHING A "MEDICALLY NEEDY" PROGRAM DESIGNED TO FINANCIALLY ASSIST THIS VULNERABLE SEGMENT OF THE OLDER POPULATION.

INADEQUATE TRANSPORTATION REMAINS A CONSISTENT PROBLEM FOR SENIOR CITIZENS. ONE FEASIBLE SOLUTION IS HELD IN THE PROPOSED LEGISLATION WHICH AUTHORIZES SCHOOL BOARDS TO CONTRACT FOR THE USE OF SCHOOL BUSES TO TRANSPORT THE ELDERLY OR HANDICAPPED. OUR HOPE FOR PASSAGE OF THIS LEGISLATION LIES IN THE STRENGTH OF YOUR SUPPORT.

THE COMMISSION ON AGING'S ROLE AS ADVOCATE FOR THE ELDERLY HAS BEEN FOREMOST SINCE ITS INCEPTION. OUR CAPACITY TO SERVE A GROWING CONSTITUENCY WILL MEET NEW CHALLENGES AS A RESULT OF CHANGES IN WASHINGTON. THE ABILITY TO MAXIMIZE OUR EFFECTIVENESS REQUIRES ADEQUATE FUNDING. WITHOUT IT, WE CANNOT PROVIDE THE SERVICES NEEDED BY A RAPIDLY GROWING SEGMENT OF THE POPULATION WHOSE OTHER SOURCES OF SUPPORT ARE VANISHING. WE APPRECIATE THE PAST SUPPORT OF THIS COMMITTEE IN ASSISTING THE COMMISSION TO SECURE ADEQUATE FUNDING. YOUR CONTINUED SUPPORT WILL BE A VALUABLE CONSEQUENCE.

PASSAGE OF THESE PROPOSALS WILL HAVE A POSITIVE IMPACT ON THE LIVES OF SENIOR CITIZENS; AN IMPACT THAT WILL MAINTAIN DIGNITY IN THE LATER YEARS.

I NOW CALL ON OUR DEPUTY DIRECTOR, MR. JIM DUBS, TO OFFER NEW LEGISLATIVE SUGGESTIONS.

Mr. James A. Dubs
Deputy Director
S. C. Commission on Aging
Columbia, SC

Mr. Dubs addressed several important areas that the Commission on Aging feels need further study and consideration for legislative action.

1. Consideration of a law which makes theft from the elderly or disabled a more serious crime with a stiffer penalty.
2. Establish a Victims Compensation Board. This would require criminals to pay into a fund which would assist crime victims. He urged support of House Bill H-2435.
3. Lack of adequate transportation.
4. Need for tax benefits for caretakers and volunteers.
5. Establish a Medical Rate Review Board to survey medical services in South Carolina.
6. Implement a tax study of the current tax burden of modest estates and the impact of inflation on elderly taxpayers.
7. Support H-2336. This bill provides for grandparents visitation rights following divorce.*

(Statement on the following pages).

Senator McLeod asked if the Commission had anything like the Medical Rate Review Board which Mr. Dubs mentioned in his presentation.

Mr. Dubs states that he was not aware of anything like this.

Senator McLeod said it seemed to him that something like this could be done. "I am not talking about mandating rates for doctors..."

Mr. Dubs does not know if they have the authority to do something about this problem, but they certainly could help to investigate it. He urged to look further into what can be done toward hospital cost escalation and make sure that physicians accept Medicare's payment as the total billing for a patient.

Senator McLeod agreed with him on the latter and that this could probably be done legislatively.

*Note: H-2336, passed, Effective date 6/2/81, Act. No. 85

TESTIMONY PRESENTED AT THE PUBLIC HEARING OF THE S. C. GENERAL ASSEMBLY COMMITTEE ON AGING

SEPTEMBER 24, 1981

BY

JAMES D. DUBS, DEPUTY DIRECTOR
SOUTH CAROLINA COMMISSION ON AGING

SENATOR RUBIN AND MEMBERS OF THE GENERAL ASSEMBLY COMMMITTEE ON AGING,

I WOULD LIKE TO REITERATE DR. FINNEY'S COMMENTS ON THE FINE WORK OF THIS COMMITTEE. THE COMMISSION ON AGING HAS ENJOYED AN EXCELLENT WORKING RELATIONSHIP WITH YOU AND YOUR STAFF, AND WE LOOK FORWARD TO ITS CONTINUATION.

THERE ARE SEVERAL IMPORTANT AREAS THAT WE FEEL NEED FURTHER STUDY AND CONSIDERATION FOR LEGISLATIVE ACTION.

THE COMMISSION'S ADVISORY COMMITTEE, MOST OF WHOM ARE OLDER PERSONS, HAS EXPRESSED FEAR OF CRIME AGAINST OLDER PERSONS AS ITS MAJOR CONCERN.

S.C. IS <u>FIRST</u> AMONG THE 50 STATES IN AGGRAVATED ASSAULTS AND IN BURGULARIES PER CAPITA. THE ELDERLY, WHO ARE CONSIDERED EASY PREY, ARE OFTEN THE VICTIMS. THEY ARE LIKELY TO SUFFER MORE FROM SUCH EXPERIENCES THAN YOUNGER VICTIMS.

IT IS ALMOST IMPOSSIBLE TO PICK UP THE NEWSPAPER WITHOUT READING OF AT LEAST ONE CASE OF VIOLENT CRIME INVOLVING AN OLDER VICTIM.

A 65 YEAR OLD COLUMBIA MAN DIED RECENTLY AFTER HAVING A HEART ATTACK ON AUGUST 25. HE WAS STRICKEN WHILE TELLING A POLICE OFFICER ABOUT AN ATTEMPTED BURGLARY AT HIS HOME.

I AM SURE THAT YOU HAVE ALL HEARD ABOUT THE TWO OLDER WOMEN RECENTLY MURDERED IN THEIR HOMES IN CLOVER.

WE NEED TO GIVE URGENT CONSIDERATION TO WAYS IN WHICH WE CAN PROVIDE MORE ADEQUATE PROTECTION TO OLDER PERSONS. WE COMMEND THOSE LOCAL LAW ENFORCEMENT AGENCIES THAT ARE INVOLVING OLDER PERSONS IN CRIME WATCH PROJECTS.

WE ASK THAT YOU CONSIDER THE NEED FOR A LAW MAKING THEFT FROM THE ELDERLY OR DISABLED A MORE SERIOUS CRIME WITH A STIFFER PENALTY. THIS WOULD NOT ONLY HELP TO DETER THE WOULD-BE THIEF; IT WOULD HELP TO EASE THE MINDS OF THE ELDERLY WHO LIVE IN FEAR OF ROBBERY AND VIOLENCE.

WE ALSO SEE A NEED FOR A VICTIMS COMPENSATION BOARD. THE ELDERLY CRIME VICTIM SUFFERS A MENTAL AND PHYSICAL TRAUMA, AND MAY BE SUBJECT TO FINANCIAL HARDSHIP AS WELL. ESTABLISHMENT OF A CRIME VICTIMS COMPENSATION BOARD WOULD REQUIRE THE CRIMINAL TO PAY INTO THE FUND WHICH WOULD FINANCIALLY ASSIST VICTIMS OF CRIMES. WE URGE YOUR SUPPORT IN THE PASSAGE OF HOUSE BILL 2435.

MANY SENIOR CITIZENS ARE CHEATED OUT OF THEIR SAVINGS BY FRAUD AND FLIM-FLAM SCHEMES. CON MEN POSE AS SOCIAL WORKERS, HOME REPAIRMEN, EVEN AS POLICE, TO GAIN ACCESS TO THE HOMES AND TO THE BANK ACCOUNTS OF THE ELDERLY.

WE COMMEND THE S.C. DEPARTMENT OF CONSUMER AFFAIRS FOR ITS EDUCATIONAL AND PROTECTIVE ACTIVITIES WHICH HAVE BENEFITED SO MANY ELDERLY SOUTH CAROLINIANS. AN EXAMPLE OF THIS GOOD WORK IS THE COOPERATIVE EFFORT OF THAT AGENCY, THE COMMISSION ON AGING, THE INSURANCE COMMISSION, AND KELLER BUMGARDNER IN SEEKING TIGHTER REGULATIONS GOVERNING THE SALE OF MEDICARE SUPPLEMENTAL INSURANCE.

THE LACK OF ADEQUATE TRANSPORTATION IS, AS ALWAYS, A SERIOUS PROBLEM FOR THE ELDERLY. THERE ARE A VARIETY OF WAYS IN WHICH LOCAL GROUPS AND INDIVIDUALS ARE ATTEMPTING TO HELP. EXAMPLES INCLUDE CAR-POOLING, USE OF VOLUNTEERS, AND REDUCED CAB AND BUS FARES. SOME OF THESE ACTIVITIES MAY BE AT ODDS WITH LAWS OR REGULATIONS GOVERNING PUBLIC TRANSPORTATION. I WOULD SUGGEST THAT A STUDY BE MADE OF PERTINENT LAWS AND PUBLIC SERVICE COMMISSION REGULATIONS TO SEE IF BARRIERS EXIST TO THESE LOCAL EFFORTS, AND, IF SO, THAT CORRECTIVE LEGISLATION BE INTRODUCED.

ANOTHER AREA OF MAJOR CONCERN, AS DR. FINNEY HAS STATED, IS THAT OF HEALTH CARE, PARTICULARLY LONG TERM CARE. IN ADDITION TO YOUR CONTINUED SUPPORT FOR THE COMMUNITY LONG TERM CARE PROJECT, THERE ARE SEVERAL OTHER SUGGESTIONS WE WOULD LIKE TO MAKE.

MANY HUSBANDS, WIVES AND CHILDREN EXPERIENCE FINANCIAL AS WELL AS PHYSICAL AND EMOTIONAL STRESS AND ARE FORCED TO INSTITUTIONALIZE OLDER FAMILY MEMBERS SO THAT MEDICAID CAN COVER THE COST. TAX BENEFITS FOR THEM AND FOR COMMUNITY VOLUNTEERS WHO SERVE THE ELDERLY ARE NEEDED. VOLUNTEERS PROVIDE MANY VITAL SERVICES, AND THE DEMAND FOR VOLUNTEERS IS INCREASING AS SOCIAL SERVICE DOLLARS DISAPPEAR FROM THE FEDERAL BUDGET.

WE ALSO SEE A NEED FOR A MECHANISM SUCH AS A MEDICAL RATE REVIEW BOARD TO SURVEY THE COSTS OF MEDICAL SERVICES IN SOUTH CAROLINA AND PUBLICIZE THE RESULTS. THIS TYPE OF INFORMATION WOULD ASSIST THE ELDERLY AND OTHERS WHO ARE SEEKING AFFORDABLE HEALTH CARE. A REQUIREMENT THAT PHYSICIANS INFORM PATIENTS OF WHETHER OR NOT THEY WILL ACCEPT MEDICARE ASSIGNMENT FOR THE TOTAL COST OF THEIR SERVICES IS ALSO NEEDED.

MAJOR FEDERAL TAX CHANGES, PARTICULARLY IN ESTATE AND GIFT TAXES WILL IMPACT MANY SENIOR CITIZENS IN THIS STATE. THESE CHANGES WILL WARRANT ANALYSIS OF SOUTH CAROLINA'S TAX STRUCTURE WITH REGARDS TO THE ELDERLY. CAREFUL STUDY SHOULD BE GIVEN TO THE CURRENT TAX BURDEN OF MODEST ESTATES AND THE IMPACT OF

INFLATION ON THE ELDERLY TAXPAYER. WE ASK THIS COMMITTEE TO IMPLEMENT A TAX STUDY AND MAKE APPROPRIATE RECOMMENDATIONS THAT WILL BENEFIT SENIOR CITIZENS THROUGHOUT THE STATE.

ON A FINAL NOTE, WE ASK YOUR SUPPORT FOR H2336 WHICH PROVIDES FOR GRANDPARENTS VISITATION RIGHTS FOLLOWING DIVORCE.

THE COMMISSION ON AGING IS FIRMLY COMMITTED TO ADDRESSING THESE CONCERNS. WITH YOUR SUPPORT, LEGISLATIVE ADVOCACY IN THIS STATE WILL HELP TO ENHANCE THE QUALITY OF LIFE FOR OUR SENIOR CITIZENS.

THANK YOU.

Mr. Frank K. McCraw
State Director for South Carolina
American Association of Retired Persons
Route 1, Box E
Cassatt, SC 29032

Mr. McCraw spoke on the top priority which the leaders of the AARP established for 1981: Inflation.

There are many problems caused by inflation for people on a fixed income. The recent trend of converting apartment complexes into condominiums is a threat to those retirees who cannot afford the high price of buying their apartment.

He addressed the problem of ever increasing health care costs and said that after having been retired for ten years, it now takes twice as much to live as when he retired. If inflation continues at the current rate, it will take four times as much to live on in twenty years. He wondered how many people are able to plan for this.

Senator Rubin agreed with Mr. McCraw on the problems caused by inflation. He called it a curse of our nation and said that it might be well to remember that this came about in large part because the American people tolerated deficit spending by the national government for some thirty years. Now the national debt is at almost $1,000 billion and the interest rates are priced accordingly.

He thanked Mr. McCraw for his presentation which is "very much on target."

AMERICAN
ASSOCIATION
OF RETIRED
PERSONS

STATE DIRECTOR FOR SOUTH CAROLINA
Mr. Frank K. McCraw
Route 1, Box E
Cassatt, SC 29032
(803) 432-4993

INFLATION

INFLATION WAS ESTABLISHED AS THE TOP PRIORITY ITEM BY THE LEADERS OF AMERICAN ASSOCIATION OF RETIRED PERSONS IN 1981. WE LIVE IN A CHANGING WORLD AND TOO MANY OF THE CHANGES INCREASE THE PROBLEMS OF PEOPLE ABOVE RETIREMENT AGE.

MANY ABOVE RETIREMENT AGE OWN THIER HOME HOWEVER THE NECESITY FOR RELOCATION DOES FIND A LARGE NUMBER DO NOT OWN THEIR HOME. MANY LIVE IN APARTMENTS WHICH DO NOT REQUIRE THE WORK OF MAINTING THE YARD AND BUILDING. WHEN MOVING INTO AN APARTMENT THEY ARE ABLE TO AFFORD THE EXPENSES HOWEVER INCRESES IN RENT PLUS INFLATION CAN MAKE IT UNAFORDABLE.

RECENTLY A NUMBER OF APARTMENTS COMPLEXES HAVE BEEN CONVERTED TO CONDOMINIUMS AND THE ELDERLY WHO MOVED INTO AN APARTMENT SO MONTHLY PAYMENTS WERE WITHIN THEIR FINANCES ARE NOT PREPARED TO PURCHASE A CONDOMIUM OR A HOME. WITH TIGHT MONEY POLICY AND HIGH INTEREST RATES CREDIT MAY NOT BE AVAILABLE.

MANY PEOPLE WHO LIVE IN APARTMENTS NEAR THE GROCERY STORE AND BUSINESS THEY PATRONIZE ARE AFRAID TO LEAVE THE APARTMENT WITHOUT A COMPANION AT DAY AND AFRAID TO LEAVE WITH A COMPANION AT NIGHT.

A MUCH LARGER PERCENTAGE OF OLDER PEOPLE REQUIRE DOCTOR AND HOSPITAL CARE, THIS HAS INFLATED IN COST MUCH FASTER THAN THE AVERAGE OF ALL INFLATION. SOCIAL SECURITY IN ORDER TO HELP WITH PROBLEMS OF INFLATION HAS PROVIDED INCREASES ONCE A YEAR BASED ON PREVIOUS INFLATION HOWEVER THE RETIREE MUST PAY THE INFLATED PRICES EIGHTEEN MONTHS BEFORE THIS IS PROVIDED. REGULAR INCREASES HAVE BEEN MADE IN THE SOCIAL SECURITY DEDUCTIONS TO HELP COVER COST OF THE PROGRAM.

THE INTEREST RATES TODAY ARE POSIBLY THE HIGHEST EVER AND WE FIND GOVERNMENT COMPETING FOR THE AVAILABLE MONEY. A CONSIDERABLE AMOUNT TO BE USED ON SPECULATION AND WHAT I CALL MONUMENTS. AT A TIME WHEN INTEREST RATES ARE SO HIGH WHY ARE GOVERNMENT AGENCIES NOT PLANING SPENDING PROGRAMS THAT DO NOT REQUIRE THE EXCESSIVE BORROWING OR PASSING UP ITEMS THAT REQUIRE INCREASED SPENDING IN THE FUTURE, SO WE CAN STOP INFLATION.

AMERICAN
ASSOCIATION
OF RETIRED
PERSONS

STATE DIRECTOR FOR SOUTH CAROLINA
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THE PUBLICITY TO THE PUBLIC TELLS US ABOUT THE PROBLEMS OF THE AUTOMOBILE INDUSTRY BUT NOT ABOUT THE TOTAL PRICE INCREASES. I PURCHASED A 1972 NEW AMERICAN MADE AUTOMOBILE IN HOPES OF BEING ABLE TO BUY A NEW CAR OF THE SAME MAKE AND TYPE WHEN NECESSARY. AFTER DRIVING THE 1972 FOR "250000 MILES I CHECKED ON THE NEW CAR AND THE PRICE WAS THREE TIMES WHAT I PAID FOR THE 1972.

THERE WAS A TIME WHEN WE FOLLOWED THE PROGRAM BUY AMERICAN. PERHAPS THIS WOULD HELP REMEDY SOME OF THE INFLATION ILLS TODAY, ALSO PROVIDE WORK FOR MANY MORE AMERICAN CITIZENS. LET US NOT BE A PARTY TO MAKING AMERICA A SLAVE TO OTHER NATIONS.

I HAVE BEEN TOLD THAT SEVENTY PERCENT OF THE SOCIAL SECURITY RETIREES ARE RETIRING BEFORE AGE SIXTY FIVE, MANY ON DISABILITY SOME AS EARLY AS IN THE THIRTIES. THIS HAS BEEN A FACTOR IN THE INCREASED DEDUCTIONS FROM CURRENT WORKERS AND A THINKING OF GOVERNMENT SUBSIDY. BOTH ITEMS HAVE CAUSED COMPLAINTS.

SO MANY OF THE CURRENT WORKERS JUST DO REALIZE THE PROBLEMS RETIREMENT CAN BRING. WITH INFLATIONOF MY THIRTEEN YEARS OF RETIREMENT THE FOLLOWING FACTS EXIST: AFTER TEN YEARS OF RETIREMENT IT TAKES TWICE AS MUCH TO LIVE ON THE SAME PLAIN AS WHEN I RETIRED. IF INFLATION CONTINUES AT THE SAME RATE IT WILL TAKE FOUR TIMES AS MUCH IN TWENTY YEARS. I WONDER HOW MANY PEOPLE ARE PLANING FOR THIS TYPE PROGRAM OR HOW MANY CAN MAKE THIS PLAN

Mrs. Randi Olafson, Director
Special Programs and Services and
Senior Employment
Richland-Lexington Council on Aging

Mrs. Olafson spoke as an advocate on behalf of the older worker. She said that the moment has come for partnership between business and direct service providers and church and community organizations. The greatest problem for a worker today is the lack of choice--you can either work full time or retire full time. Business can help by reappraising their work and retirement policies.

She referred to certain steps which the Travelers Insurance Company has taken to help their employees: they have eliminated mandatory retirement. Further they set up an extensive pre-retirement counseling program, including second career planning, housing and health, with the direction toward all employees. They established a retirees job bank and used Travelers retirees to work in temporary jobs and job sharing within the company. They surveyed all their departments to establish which jobs could be part time jobs and filled them with retirees. In addition, they hired retirees to use vans--which the Company had purchased to carpool their employees--during the day to transport older persons to doctors and shopping. This is just one company which demonstrates how business can help service providers establish new as well as expand existing services not just with monetary support but use of existing resources.

She reported that due to a Department of Labor grant this past year, the Seek-A-Senior Program has made 560 client referrals, over 150 of those being new applicants to the Program and made 175 job placements. Beginning October 1, 1981, Richland County Council has shown them their support by funding the Program.

In closing, she quoted George Bernard Shaw, "Nothing is worth doing unless the consequences could be serious."

Senator Rubin expressed his appreciation to Mrs. Olafson for her presentation and said it is encouraging to see more and more large business firms develop programs of assistance to the elderly. "The educational process is going on."

RICHLAND-LEXINGTON COUNCIL ON AGING
J. W. Witherspoon, Jr.
President
Fletcher Spigner
Executive Director

1800 Main Street - Suite 3-C
Columbia, South Carolina 29201
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September 24, 1981

REPORT TO THE LEGISLATIVE STUDY COMMITTEE ON AGING
PREPARED BY (MRS.) RANDI OLAFSON, DIRECTOR
SPECIAL PROGRAMS AND SERVICES AND SENIOR EMPLOYMENT
RICHLAND-LEXINGTON COUNCIL ON AGING

SENATOR RUBIN, HONORABLE COMMITTEE MEMBERS AND FRIENDS OF OLDER AMERICANS: I AM SO PLEASED TO APPEAR BEFORE YOU FOR THE THIRD YEAR AND HAVE THE OPPORTUNITY TO ADVOCATE ON BEHALF OF THE OLDER WORKER. A FACT WE ARE ALL AWARE OF BUT OFTEN CHOOSE TO IGNORE IS THAT AGING IS THE ONE THING THAT DOES NOT DISCRIMINATE...WE ALL HAVE TO FACE IT SOONER OR LATER. HOW MUCH BETTER IT IS TO BE SOCIALLY, ECONOMICALLY AND PSYCHOLOGICALLY PREPARED FOR IT SOONER. WE ARE ALL AWARE OF THE STAGGERING PROJECTED STATISTICS CONCERNING THE POPULATION TO BE 65+. PRESENTLY, THERE ARE 3.6 MILLION PERSONS 65+ WHO ARE AT OR BELOW POVERTY LEVEL, AND ACCORDING TO THE U.S. CENSUS BUREAU IN 1979, ONE-HALF OF ALL RECIPIENTS OF SOCIAL SECURITY HAVE NO OTHER INCOME. THIRTEEN PERCENT OF ALL FOOD STAMP RECIPIENTS ARE ELDERLY. WHERE DO WE TURN? THE BURDEN IS ON SERVICE PROVIDERS, WHO ARE FACING FUNDING CUTBACKS ALSO, TO BE MORE CREATIVE IN THEIR USE OF THE MONEY THEY DO HAVE. THE BURDEN IS ON THE CHURCH COMMUNITIES. THE BURDEN IS ON THE PRIVATE SECTOR.

AT THE NATIONAL COUNCIL ON THE AGING CONVENTION IN MARCH, MR. MORRISON H. BEACH, PRESIDENT OF THE BOARD OF DIRECTORS FOR TRAVELERS INSURANCE, SPOKE TO MORE THAN 2,000 SERVICE PROVIDERS ABOUT HOW HE SEES THE RESPONSIBILITIES OF THE PRIVATE SECTOR. ALL OF OUR FUTURE SECURITY DEPENDS ON A WORK HISTORY - SOCIAL SECURITY, PENSION AND PERSONAL SAVINGS. MR. BEACH SAID THAT HE SEES THE "GREYING OF AMERICA" AS A BLESSING, NOT A BURDEN AND AMERICAN BUSINESS CAN PLAY A VITAL ROLE IN SECURING THIS. THE MOMENT HAS COME FOR PARTNERSHIP BETWEEN BUSINESS AND DIRECT SERVICE PROVIDERS AND CHURCH AND COMMUNITY ORGANIZATIONS.

THE GREATEST BARRIER FOR A WORKER TODAY IS THE LACK OF CHOICE...YOU CAN EITHER WORK FULL TIME OR RETIRE FULL TIME. THEREFORE, BUSINESS CAN HELP BY REAPPRAISING THEIR WORK AND RETIREMENT POLICIES. THERE WILL BE A 30% REDUCTION IN ENTRY LEVEL WORK FORCE BY THE MID 1980's ACCORDING TO THE DEPARTMENT OF LABOR AND 55% OF THE LABOR FORCE WILL BE OVER 55 BY THE YEAR 2000.

A LITTLE-NOTED TREND IN THE NUMBER OF WORKERS RETIRING EACH YEAR UNDER SOCIAL SECURITY IN THE 1970's SUGGESTS THAT THE GROWTH IN RETIREMENT IS RAPIDLY DECLINING. A MAJOR REASON FOR THIS, I BELIEVE, HAS BEEN THE HIGH LEVELS OF INFLATION IN THE LATER YEARS OF THE 1970's DECADE, EXTENDING INTO 1980. WORKERS NEARING SO-CALLED RETIREMENT AGE MUST BE HAVING SECOND THOUGHTS ABOUT LEAVING THE LABOR FORCE COMPLETELY. DESPITE THE AUTOMATIC COST-OF-LIVING INCREASE IN SOCIAL SECURITY BENEFITS (WHICH IS CURRENTLY BEING THREATENED) OTHER SOURCES OF RETIREMENT INCOME, INCLUDING PRIVATE PENSIONS, CANNOT BE RELIED UPON TO KEEP UP WITH ACTUAL AND EXPECTED RISES IN THE COST OF LIVING FOR SUCH WORKERS AND THEIR FAMILIES. THERE ALSO MIGHT BE A NEW RETIREMENT CONSCIOUSNESS DEVELOPING IN THIS COUNTRY, WHICH IS MAKING OLDER WORKERS RE-EXAMINE THE COSTS OF RETIRING PREMATURELY. SOME OF THEM MAY BE LEARNING ABOUT THE FACT THAT IN RECENT YEARS THE AVERAGE NUMBER OF YEARS A PERSON CAN BE EXPECTED TO LIVE AFTER REACHING 60 OR 65 HAS BEEN INCREASING. IF THEY ARE IN GOOD HEALTH, THEY MIGHT BE WONDERING IF LONG YEARS IN RETIREMENT ARE BETTER THAN STICKING IT OUT IN THE LABOR FORCE FOR JUST ONE OR TWO MORE YEARS. WE DON'T KNOW IF THIS DECLINE WILL CONTINUE, BUT IF IT DOES, IT WILL GREATLY AID MUCH OF THE SHORT TERM FUNDING PROBLEM OF THE OASI PART OF SOCIAL SECURITY.

ADDITIONALLY, IF SOME OF THE FOLLOWING THINGS THAT TRAVELERS INSURANCE HAS DONE WERE MODELED BY OTHER COMPANIES, IT WOULD HELP TO ALLEVIATE MANY OTHER PROBLEMS ON ALL LEVELS. TRAVELERS HAS ELIMINATED MANDATORY RETIREMENT.

ALSO, AFTER TAKING A POLL OF RETIREMENT-READY WORKERS, THEY FOUND THAT 85 PERCENT EXPRESSED AN INTEREST IN PAID EMPLOYMENT AFTER RETIREMENT. THEY SET UP AN EXTENSIVE PRE-RETIREMENT COUNSELING PROGRAM INCLUDING SECOND CAREER PLANNING, HOUSING AND HEALTH, WITH THE DIRECTION TOWARD ALL EMPLOYEES -- EMPHASIZING A FULL LIFE PLANNING PROGRAM RATHER THAN JUST A FEW YEARS PRE-RETIREMENT. THEY ESTABLISHED A RETIREES JOB BANK AND USED TRAVELERS RETIREES TO WORK IN TEMPORARY JOBS AND JOB SHARING WITHIN THE COMPANY WHICH DID NOT REQUIRE CONTINUITY FOR EFFICIENCY. THEY ALSO SURVEYED ALL DEPARTMENTS WITHIN THE COMPANY TO ESTABLISH WHICH COULD FEASIBLY BY PART-TIME JOBS AND FILLED THEM WITH RETIREES. A FEW YEARS AGO, THE COMPANY PURCHASED VANS TO CAR-POOL THEIR EMPLOYEES. ONE DAY, MR. BEACH OBSERVED THAT THE VANS WERE IDLE ALL DAY, SO HE HIRED RETIREES TO DRIVE THE VANS DURING THE DAY TO TRANSPORT OLDER PERSONS TO DOCTORS AND SHOPPING.

BUSINESS CAN ALSO HELP SERVICE PROVIDERS ESTABLISH NEW AND EXPAND EXISTING SERVICES NOT ONLY WITH MONETARY SUPPORT BUT USE OF EXISTING RESOURCES WITHIN THE COMPANY. IN THE COLUMBIA AREA, FOR EXAMPLE, A MAJOR BANK HAS MANY EXECUTIVES MAKING TELEPHONE REASSURANCE CALLS AND DELIVERING MEALS ON THEIR LUNCH HOUR. BUSINESS CAN ALSO HELP BY SERVING THE OLDER PERSON AS A CONSUMER BY EXPANDING DISCOUNT EFFORTS. LASTLY, BUSINESS CAN HELP FOSTER NATIONAL ECONOMIC GROWTH BY SUPPORTING A HEALTHY, GROWING, NON-INFLATIONARY ECONOMY.

MR. BEACH IS CERTAINLY A MAN WITH VISION AND HEART. HE IS INSPIRING AND SERVES AS A PRIME, OPTIMISTIC EXAMPLE OF WHAT CAN AND MUST BE DONE. THERE ARE MANY SUCH PEOPLE WITH VISION AND HEART IN THIS COMMUNITY. WE ALL DEPEND ON THE VISIONS AND LOVE OF EACH OTHER.

I AM PLEASED TO REPORT THAT, DUE TO OUR DEPARTMENT OF LABOR GRANT THIS PAST YEAR, THE SEEK-A-SENIOR PROGRAM HAS MADE 560 CLIENT REFERRALS, OVER 150 OF THOSE BEING NEW APPLICANTS TO THE PROGRAM AND MADE 175 JOB PLACEMENTS. BEGINNING OCTOBER 1, 1981, RICHLAND COUNTY COUNCIL HAS SHOWN US THEIR SUPPORT BY FUNDING THE PROGRAM.

THANK YOU FOR YOUR KIND ATTENTION AND YOUR CONTINUED SUPPORT. IN THE WORDS OF GEORGE BERNARD SHAW, "NOTHING IS WORTH DOING UNLESS THE CONSEQUENCES COULD BE SERIOUS."

This concluded the list of persons speaking during the morning session. Before the Committee recessed for lunch, Senator Rubin read the names of the delegates and observers to the White House Conference on Aging who were present.

Representative Dill Blackwell, Ms. Gene Brading, Helen Brawley, Nellie Claire Brown, Harry Bryan, Harold Dye, Eugenia Evans, Dr. Ernest Finney, Leroy Fyall, Queen Johnson, Phyllis Pellarin, Birdie Pompey, Helen Propst, Edward Rushton,

Going as observers are: Tom Brown, George Dick, Barbara Jones, J. W. Lawrence, Suzanne Lewis, Sam Waldrep, Carrie C. Washington, and Alleen Wood.

Mrs. Beverly Craven, Chairman
S. C. Commission on Women
P. O. Box 11467
Columbia, SC 29211

Mrs. Craven presented the following recommendations:

1. Equitable Distribution of Property
2. Probate Reform Code
3. Amendment to Horizontal Property Act

(Statement on the next page).

Senator Rubin thanked Mrs. Craven for the work the Commission is doing.

South Carolina Commission on Women

P. O. BOX 11467, COLUMBIA, S. C. 29211

STATEMENT BEFORE PUBLIC HEARING OF THE S. C. STUDY COMMITTEE ON AGING

BLATT BUILDING, September 24, 1981

My name is Beverly Craven. I am chairman of the S. C. Commission on Women. Our Commission is a small state agency whose function is to study the status of women and their legal treatment in all facets of living, particularly in regard to any discrimination that may exist. We are to make recommendations for change to those governmental leaders who can effect such change and disseminate information related to the rights, responsibilities and status of women.

Since 59% of all persons over the age of 65 years are female, we feel that it is proper that we appear here today to add our voice to those of other individuals and organizations, both governmental and otherwise, who are here to express their feelings to the Study Committee on Aging.

The Commission on Women has had legal research done and have published pamphlets which are free upon request on the subjects of Will and Estates; Credit, Marriage and Divorce; parental rights and responsibilities, education, employment, property rights and health care.

The information received from our research and from the many calls and letters we receive leads us to make the following recommendations:

Equitable Distribution of Property

A bill which specifies criteria to be considered by the Court when making an equitable distribution of marital property, including the contribution of a spouse as a homemaker, passed the House this year and hopefully will be passed by the Senate this coming year. We urge the passage of this Legislation.

Probate Reform Code

We strongly support the passage of legislation which will allow for a spouse and or children to receive the entire intestate estate.

Amendment to Horizontal Property Act

We support S-289 and H-2517 which are intended to protect the rights of tenants at the time of a conversion of rental units to condominium ownership.

We would also like to commend those agencies dealing with displaced homemakers and spouse abuse, and urge them to be vigilant to the needs of older women.

Thank you for giving us the opportunity to appear before you. Our Commission will be happy to work with you in any way you feel we can be benefical.

George Dick
Senior Aging Program Planner
Central Midlands Regional Planning Council

Mr. Dick's presentation addressed the involvement of Area Agencies on Aging in development of long term care systems for the elderly.

The Agency's aging program planning activities have been geared to meeting the needs of both future elderly citizens as well as those individuals currently considered elders of our society. They are currently working with the South Carolina Commission on Aging and Community Care, Inc. on a project which involves the total care community in the Columbia area. This project which is funded through a private foundation seeks to assess and meet the needs of the health impaired elderly through a coordinated system of services.

Mr. Dick's Area Agency on Aging is ready to assist the State in its efforts to stabilize health care costs associated with the older population. They feel that they now have the experience to deal with development of long term care in their region.

(Statement on the following pages).

Senator Rubin expressed his appreciation for all this Agency is doing which is very helpful to the citizens of our State, and assured him that the Committee will be working with him.

STATEMENT AT THE PUBLIC HEARING OF
THE SOUTH CAROLINA STUDY COMMITTEE ON AGING
BLATT BUILDING, ROOM 100/110
COLUMBIA, SOUTH CAROLINA

Senator Rubin, members of the Study Committee on Aging. Thank you for giving me the opportunity to present testimony for your consideration today. My name is George Dick and I represent the Central Midlands Regional Planning Council, which is our Region's Area Agency on Aging.

Before I get to the heart of my comments, I feel compelled to present an overview of our Area Agency on Aging operations.

The Central Midlands Region is a dynamic area in which to work and has a dynamic older population. This can be seen through a quick glimpse of our Region. The Region has a county with the most dense elderly population in the state (Richland); it also has one of the fastest growing counties (Aging population) in the state (Lexington); it has the county with the highest ratio of elderly to other population (Newberry); and finally it has one of the most rural and poor counties in the state (Fairfield).

The Central Midlands Regional Planning Council takes its role as an Area Agency on Aging very seriously. Because of this, we can proudly point to the Aging Network services of our Region as fine examples of what can be done with less, when dedicated professionals work closely together.

We are not alone in recognizing this. Many national organizations have recognized our efforts and made a point of seeking us out. The National Council on Aging leans heavily on our local service providers when evaluating training techniques for senior center personnel. This week the Executive Director of the Richland-Lexington Council on Aging has been asked to personally evaluate training being conducted in Charleston (one of only two such requests nationally). Also, our Region's Aging programs have been written up in a national publication outlining innovative programming ideas.

Finally, the Central Midlands Regional Planning Council was selected as one of ten Area Agencies on Aging nationwide to be profiled as an example of how Area Agencies operate. This profile was then used to demonstrate the concept of Area Agencies on Aging to the U. S. House of Representatives and Senate, as well as many other national organizations. I have included a news article drawn up for use in the Administration on Aging's national newsletter which will give you an overview of the profile (ATTACHMENT I). I hope you will have an opportunity to read it at a later time.

Senator Rubin, Committee Members. There are many examples I could cite which would amplify what we feel are our accomplishments; however, I am here to speak on a related but different topic-- involvement of Area Agencies on Aging in development of long term care systems for the elderly.

The National Association of Area Agencies on Aging (N4A) has been attempting to develop an overall position statement on Area Agencies on Aging and their

relationship to development of long term care systems. The specifics of that work can be found in ATTACHMENT II. However, I would like to indirectly stress a few points which you will find included in the material mentioned (which I have extracted from a more complete overview of Area Agency on Aging function statements). I encourage you to take a moment later to review the content of ATTACHMENT II.

The Central Midlands Region of South Carolina has experienced a growth in the elderly population which is reflected state and nation wide. This growth, as you are already aware, is only a small indication of things to come. Because of this, our Aging program planning activities have been geared to meeting the needs of both future elderly citizens as well as those individuals currently considered elders of our society. This is no small task, but with extremely good local support, participation, and coordination, we are beginning to see progress being made.

Last year I appeared before you and spoke of a need for preventive health care for older people. Since that time, we have been fortunate to have a local hospital (Richland Memorial Hospital) take on the leadership role in developing such a pilot program. Hopefully if the program proves successful here, it can be expanded throughout our Region and eventually throughout the state.

I speak of this example because I brought it to you last year, but there are many others. We are currently working with the South Carolina Commission on Aging and Community Care, Inc. on a project which is involving the total

care community in the Columbia area. This project (totally funded through a private foundation) seeks to assess and meet the needs of the health impaired elderly through a coordinated system of services. We are also constantly updating our Region's network of services as the needs of the Aging population become clearer and more easily measured.

Our Area Agency on Aging stands ready to assist the State in its efforts to stabilize health care costs associated with the older population. We stand ready because we feel we now have the experience to deal with development of long term care in our Region. We offer that experience to you for your use.

As pointed out in the position statement which I have attached, there is a long term care network in place. To properly develop that network, we have to recognize it and use it. That network in South Carolina is headed by the South Carolina Commission on Aging, and filled out by Area Agencies on Aging througout the state.

If the Committee would like a more in-depth overview of what an Area Agency on Aging is, I would be very happy to meet with you. Thank you for allowing me time to present this to you. If you have any questions, I would be happy to answer them.

ATTACHMENT I

THE AREA AGENCY ON AGING IN SOUTH CAROLINA'S MIDLANDS...A PROFILE

Following is the th in a 10-part series focusing on area agencies on aging across the country. The agencies were among the participants in a recent profile survey conducted by the National Association of Area Agencies on Aging (N4A).

Representatives of the 34 city and county governments which make up South Carolina's Midlands felt as early as 1974 that Central Midlands Regional Planning Council was the natural organization to plan for the care of the elderly.

Recognizing that the elderly should not be isolated, but integrated into community life, they could see the value of integrating planning for senior citizens into the overall scheme of planning for the community as a whole.

The growing Midlands region is a mixture of urban and rural counties whose population increased nearly 24 percent in the past decade, 11.2 percent of them elderly. Its four counties are centered around Columbia, the capital of South Carolina which has been ranked by "Money Magazine" as the nation's third best retirement state for the 1980's.

Before making the move, members of the Regional Planning Council considered the advantages of shouldering the responsibility for aging planning.

Among them, the council was an existing agency with experience. It was a council of governments created by, governed through and directly accountable to local governments which were being approached for the first time for local funding by agencies serving the elderly. And it had a proven track record in tackling such regionwide problems as crime, housing, recreation, transportation and health care...problems which often hit hardest at the senior citizen.

And they considered the disadvantages.

The council would have to make a strong commitment to the aging cause to assure its position as a top priority among the council's many planning activities.

As the council's executive director, Sidney F. Thomas, Jr., recalls, it was with enthusiasm that local government officials on the council made the commitment and voted in 1974 to expand its umbrella of comprehensive community planning to include a full-fledged aging program.

Within months George Dick, an experienced aging planner, was on board. A full-time nutrition program director, aging planning coordinator, and bookkeeper were later added, and the council assigned its housing and transportation planning experts to make special studies of the needs of the region's elderly in those two critical areas.

The council created a regional aging advisory committee, 60 percent of whom were 60 years of age and over, and named as chairman an influential county councilman who represented his community on the Regional Planning Council.

The group rolled up its sleeves and went to work on behalf of senior citizens. Advancing on the State Capitol, they waged a successful campaign among Legislators seeking passage of a Homestead Exemption Act and other relief measures for older citizens.

But there were other battles to be fought.

The four county region was still considered a "low impact" area in terms of its need for federal assistance under the Older Americans Act. This despite the fact that the region had the state's second highest population of persons 50+ and one of its counties had the highest percentage of older citizens of any of the 46 counties in the state. The Regional Planning Council successfully

petitioned the S. C. Commission on Aging for a change in that status in 1976. With that change came designation of the council as the region's Area Agency on Aging.

Another major problem encountered as the aging program got underway was the large number of organizations competing for the limited federal funds available. This had resulted in agencies working at cross purposes, spreading of funds too thin to support an adequate level of services, wasteful duplication and general confusion for senior citizens uncertain about where to turn for help.

The council set about identifying those organizations most successfully serving senior citizens, persuaded others to voluntarily give up service funds to those agencies better qualified and established a strong network of service agencies which began holding monthly "Team Meetings" in the spring of 1975.

This team concept resulted in a sharing of ideas and services. The region's "Aging Team" fosters not only cooperation, but enables a sharing of expertise and services which have made the aging dollar go farther.

The Regional Planning Council, whose members include mayors and city and county councilmen, has enabled the local elected official to become directly involved in the planning function. This has proved to be a happy marriage. Working side by side with the elderly and the agencies which serve them has made the elected official more aware and receptive to their need for local financial support.

In 1974 counties in the Midlands contributed a grand total of $6,400 to agencies serving the elderly. That year funds from all sources totaled only $255,000. This year those agencies will be receiving county dollars totalling $368,000...which will make possible a $2 million dollar aging program in fiscal year 1982.

And that's just the cash contributions. There are many more examples of community support...schools opening their cafeterias to senior citizens at lunch time; city-owned buildings made available rent-free for use as senior centers; former school buildings renovated as centers and meal sites; local recreation commissions making room in conveniently located facilities for senior programs, activities and crafts stores.

The region has come a long way in developing ways to care for its senior citizens.

Role of Council as Area Agency on Aging

While most of the service activity is contracted by Central Midlands Regional Planning Council to service providing agencies, as the Area Agency on Aging, the council is directly involved from the birth of an idea, through its funding, to delivery of that new service to a senior citizen somewhere in the 2,800 square mile region.

The council's staff has the responsibility for assessing the needs of and planning programs for older people, providing service agencies with technical assistance on both program and fiscal matters, monitoring and evaluating those programs, reporting the results, and serving as the region's advocate for the elderly.

In an effort to improve service efficiency, the council in 1976 became the first Area Agency on Aging in South Carolina to directly contract with caterers for nutrition services. This move provided immediate results. Group and home-delivered meals were expanded beyond the region's two metropolitan counties into two poorer rural counties for the first time. There was dramatic improvement not only in service efficiency and availability, but in food wastage which dropped from 25% to less than 1%. Buying meals for a four-county area also produced a lower per-meal cost. Later that

year the council agreed to become the pass-through agent for funds available for senior citizens through Title XX of the Social Security Act.

A procedure to handle pass-through funds was developed to ensure that their administration provided little frustration to the agency whose main mission is providing services. Action was taken to consolidate reporting forms, lessening the burden of excessive paperwork. Staff assisted the agencies in redesigning their fiscal accounting systems.

Attention to developing the capacity of service delivery agencies has become an increasingly important part of the work done by the staff of the Regional Planning Council. This has included work in reorganizing a rural county council on aging, developing policy guides for governing boards and administrative staffs of existing councils on aging, and a major role in helping the state's fastest growing county establish its first independent comprehensive aging program. Using the Regional Planning Council's communications staff, brochures and radio and television campaigns have been developed to help local agencies make senior citizens aware of services available to them.

The Regional Planning Council also conducts an on-going program providing workshops and seminars for the staffs of service providing agencies on such subjects as: management skills, legal advocacy training, fiscal matters, nutrition site managers training, training for outreach workers and their supervisors, arts and crafts programs, and more.

Seeking innovative ways to identify and resolve problems encountered by the older person in today's society, the Regional Planning Council is currently involved in a privately-funded $1 million project to foster health care coordination for the community's health impaired elderly. It is one of eight pilot projects being conducted nationwide. The council also hosts

monthly meetings of South Carolina's Federation of Older Americans Legislative Forum.

While the Regional Planning Council does not deliver services directly, it is committed to a "hands-on" role in the community. Staff planners can be found participating in senior citizen events ranging from a city's Hootenanny to a county picnic, from the Senior Olympics to a Senior Center's dance, and from accompanying volunteers in distributing home-delivered meals to attending monthly board meetings of the various local councils on aging.

Services Funded

Health: Currently funded by the Robert Wood Johnson Foundation is a Health Impaired Elderly Coordination project which seeks to link a comprehensive health and social services system to those elderly in need of such a service. Scheduled to begin operations this fall is a well elderly program of preventive health care through local hospitals and health districts, supported by local funds, Medicaid, Medicare, and possible grant funds.

Nutrition: The region has 18 home-delivered and congregate meal sites serving approximately 1,200 hot meals daily. This service is funded through the Older Americans Act, Social Security Act (Title XX), local county government funds, and full-pay participation by some older clients.

Legal Services: A local agency with a full-time attorney on staff has been contracted by the region to provide advocacy training for all outreach nutrition site and senior center personnel. Assistance is provided to senior citizens with probelms in such areas as benefits law, Social Security, property rights, Medicaid and Medicare.

Support Services: The Regional Planning Council contracts with service agencies for a number of support services designed to keep older people in their own community as long as possible. The services include: homemaker,

transportation, shopping assistance, escort, information and referral, and outreach. They are funded by many sources including Older Americans Act, Social Security Act and local funding.

Employment: Established in two of the region's four counties is an employment referral service. This program provides employment counseling and placement services, and is funded fully through a grant from the State Employment Service.

In the seven years since the Regional Planning Council first became involved with planning for the elderly, there has been not only an increase in local and federal financial support, but there has been an expansion of service to areas of great need and a remarkable awakening of community interest in the plight of the elderly.

This was demonstrated over the past year when more than 1,800 persons showed up at 100 locations throughout the region to begin shaping their comments for the upcoming White House Conference on Aging. That national conference, set for Washington in December, will likely effect how this nation takes care of its elderly for years to come.

SKELINES

#1	A Blind Client Is Transported To Her Senior Center
#2 and #3	A Proud Lady Receives A Visitor From The Council on Aging
#4	Quilting Bee - Senior Center Style
#5	Staffers Introduce A 114-Year Old Guest During County Picnic
#6	Exercise Class At Local Senior Center
#7	Student Assists Senior Citizen During Lunch At Elementary School Cafeteria

III. Future National Aging Policy Issues

A. Demographic Changes

There is no question our society is facing a tremendous change in the demographics of our population: We are turning from a "young" society to an "older" society; the fastest growing segment of our population is that group aged 75 and over; the elderly are migrating to certain sun-belt States; and as a group, the elderly are healthier today then they were just a few years ago.

It is also anticipated that there will be a dramatic shift in the employment status of the elderly. As persons remain healthier in advancing years, as the mandatory retirement age is raised, as retirement incentives are offered for those who remain in the work force longer, and as the availability of young persons entering the work force diminishes in the near future, we may see a shift in employment/retirement policy directed at those 70 years of age rather than the current 60 years. How this shift will impact aging policy and supporting services delivery must be addressed by the Network on Aging.

B. Economic Changes

While many reports indicate the elderly as a group are more financially secure today than in the past, that does not negate the fact that there are growing disparities: Inflation has been decreasing actual buying power of those on social security and fixed retirement incomes; and a sizeable portion of the elderly are living below even the lowest government established poverty level incomes.

Perhaps of greatest economic significance in the future will be problems and needs of those elderly not in the lowest income levels but those in the lower middle income levels. Many of these elderly are currently in

their sixties and managing on retirement incomes and social security and may have small savings and equity in their homes. The fact is, these individuals may soon be the casualties of our nation's current aging policy. These are the elderly who are able to provide for themselves today, but whose finances and equity can be easily wiped out through one major illness. Medicare covers only partial costs and because these individuals may not be eligible for Medicaid, savings are depleted first, and next, the equity in their home may be depleted. Even if an individual remains in their home following a major illness, the lack of cash flow and/or a lack of availability of in-home supporting services, can result in inappropriate and expensive institutionalization - the only solution under our current aging policy and resulting service delivery systems.

This situation, which already occurs all too often, results in a great burden on our society, not only monetarily but also psychologically, as attitudes change toward the elderly who are viewed as a burden on the federal budget.

Several alternative economic approaches are being espoused for meeting the growing needs of the elderly population who cannot manage without some supportive intervention.

1. Shift from public expenditures to private voluntary/corporate expenditures as well as from non-service and family support systems.

   There may be no quarrel regarding this shift in emphasis since the Area Agencies have always been challenged to tap resources from whatever source available. Frankly, policy makers and Administration officials are frequently surprised when they learn of the extent Area Agencies have already been innovative in tapping the private sector on behalf of the elderly.

The key issue here is whether sufficient resources are in fact available from other than the public sector. It is dubious whether the private corporate and voluntary sector is currently willing to accept the responsibility for augmenting public resources in providing the needed community/in-home supports.

This then presents a challenge for the Area Agencies over the next several years - what role will it be necessary for us to assume in educating the private sector regarding elderly needs as well as in presenting innovative opportunities for the private sector to be responsive.

2. Shift from dependency on the Social Security System to emphasis on private pension plans and individual savings.

   Again, one may or may not dispute this shift in emphasis, however, this will not solve the financial problems of those elderly currently retired or who are soon to retire from employment situations which have not been covered by private pension plans. The challenge for the Area Agencies will be to ensure that those elderly impacted by the growing disparity between fixed incomes and buying power have access to supporting services they need.

3. Still another alternative economic approach is to assess the effectiveness of our nation's current service delivery systems and to shift the flow of substantial public resources from medical and institutional elderly care programs to community based and in-home supporting services.

   This shift presents still another challenge to the Area Agencies. How to plan, coordinate and provide leadership in putting together the best mix of services at the local level to meet the needs of today's

and tomorrow's changing elderly population.

We are challenged to keep bringing to the attention of our policy makers and administration officials examples such as these:

a. An elderly man in Ohio chooses to stay on expensive medication rather than eat fresh fruit daily simply because, as he points out to the doctor, that medicare/medicaid will pay for his drugs while he does not have enough money to purchase fresh fruit for his diet.

b. The annual public expenditures going into institutional care for five percent of Wisconsin's elderly population is larger than the total OAA Title III appropriations for community based and in-home services nationally.

The Network on Aging and the Area Agencies must convince our policy makers to reassess the use of public expenditures and to consider creating an equitable balance between institutional care which is needed for approximately five percent of our elderly population and community based and in-home supporting services designed to keep people in their homes and out of inappropriate institutionalization. We must avoid creating dependency on medical and institutional care for our elderly.

We must as a society, look at that relationship between our health care service system and the community based and in-home supporting services system. Frankly, our society will not be able to support the existing care systems in the future. Area Agencies will be challenged to take a leadership role in changing attitudes toward the elderly and the kinds of services they need.

C. Attitudinal Changes

Statements by former Administration officials regarding the "greying of the federal budget", recent articles in the Miami Harold referring to the elderly as a drain on our society, and statements about how the young wage earner is carrying the burden of our retired elderly under our current Social Security System, are of great concern to those dealing with the needs and problems of the elderly on a day-to-day basis.

There are differences of opinion even among academicians, researchers, and practitioners in the field of gerontology, regarding the issue of age irrelevancy and whether the Network on Aging is working toward the development of a separate service delivery system only for the elderly at the expense of the rest of the society.

These attitudes present still another challenge to the Area Agencies and the Network on Aging. First, the Area Agencies have never been about the business of creating a separate service delivery system for the elderly. Our focus is to work toward a comprehensive community based service delivery system that is responsive to the elderly - our society and the economy could not afford to maintain separate service delivery systems for every age category and neither the Area Agencies nor N4A have ever advocated for such.

Second, the age irrelevancy issue appears to be adding fuel to the fire relative to society's negative attitude toward the elderly. The question ought to be asked: "Since when has age not been a relevant issue?" It certainly has been in the past when our public resources were heavily channeled to programs geared to our "young" society; when numerous federal, State and local programs sprung up for young persons, and when the education system flourished and new schools sprung up across the country.

Today, schools remain empty because of declining enrollment. Yet, many local school officials are unwilling to allow them to be used for elderly programs. In other cases, school buses will remain idle while the Network on Aging is struggling to put together local alternative transportation systems to serve the elderly. When school bond issues are voted down by the "elderly vote", people charge "age segregation" or "ageism" when in fact, the elderly are reacting to the unresponsiveness of local officials. Consequently age is a factor in setting social policy - it has been in the past and shall remain so in the future - to think otherwise is academic folly.

Therefore the challenge is before the Network on Aging to assist the general public and the policy makers understand the realities of a changing society: The demographic factors, the economic factors, and societal attitudes, which will have a major impact on our future national aging policy.

In order to proceed with recommendations for future N4A initiatives, an agreed upon role for Area Agencies and the Network on Aging was necessary. Even though that role is perceived differently by individual Area Agencies as well as those outside the Network on Aging, the statement set forth in the following section has been adopted by the N4A Board.

IV. Role of Area Agencies in Future Aging Program Initiatives

After extensive discussion, the N4A Board has agreed that the Older Americans Act is basically a sound programmatic approach to addressing the needs of the nation's elderly and will use the Act as the basis from which our future activities evolve.

A. N4A believes the legislative intent of the OAA remains valid in future national aging policy.

The planning, coordination and leadership responsibilities set forth in the Act should continue to provide the administrative focal point for bringing about necessary changes in our service delivery systems so that public and private resources are responsive to those elderly in greatest economic or social need.

B. N4A's Long Term Care Survey Report indicates eighty percent (80%) of the Area Agencies saw the development of Long Term Care services in their role of developing a comprehensive and coordinated services system as a priority.

According to the definition used in the N4A Long Term Care Survey indicates that Area Agencies are to some degree already involved in long term care related activities. The definition used:

> "The phrase 'long term care' typically represents a range of services that addresses the health, social and personal care needs of individuals who for one reason or another have never developed or have lost some capacity for self care. Services may be continuous or intermittent, but it is generally presumed that they will be delivered for the 'long term', that is, indefinitely, to individuals who have a demonstrated need, usually measured by some index of incapacity."

The following diagram sets forth how N4A views the long term care, or what we will refer to as the "continuum of community based and in-home care" concept and the role Area Agencies can or are assuming in that concept.

However, many obstacles hamper the Area Agency's effectiveness in this area. For example, the Long Term Care Survey also indicates that only thirty-five percent (35%) of the Area Agencies stated that as currently structured, the Area Agency had the capacity to carry out its role in the development of long term care services as part of a comprehensive and coordinated service system; firty-four percent (54%) said they were not; eight percent (8%) did not know.

In the next section of this Statement, proposals are made for future N4A activities which address the previously identified challenges and which will help alleviate some of the obstacles confronting Area Agencies as they carry out their OAA role.

C. N4A also disagrees with those persons who claim that an entirely new long term care network needs to be established in this country.

First, we do not believe our national resources provide us the luxury of establishing a new continuum of care system. Secondly, we do not believe it is necessary to establish a new system since the already existing Network on Aging can play a key role in designing and implementing a continuum of care system that is responsive to the elderly.

Action steps laid out in Section V of this Statement address themselves to some of the challenges and barriers we see ahead in implementing our proposed strategy in the future.

V. N4A Mission Statement

A. Goals and Objectives

Basically, N4A's future goals and objectives will remain as they have been but with an emphasis placed on the identification and utilization of private voluntary and corporate resources and non-service approaches to meet certain needs of the elderly, and to enhance family support systems.

1. Goals

a. To increase appropriate utilization by the elderly of public and private resources with emphasis on underserved populations.

b. To increase the effectiveness and efficiency of AoA, State and Area Agencies in managing a continuum of community based and in-home care for the elderly.

2. Objectives

a. Assist the Congress, Administration officials, and the general public understand issues in service delivery to the elderly at the local level, focusing primarily on community based and in-home services.

b. Expand the availability of services provided in the community and in the home.

c. Avoid premature and inappropriate institutionalization of the elderly.

d. Assemble the best mix of services available to the elderly in need at the local level.

e. More effecitvely utilize limited public resources.

f. Maximize private voluntary and corporate sector participation

and resource allocations.

g. Maximize elderly input and participation in determining the ultimate mix of services available at the local level.

h. Assist N4A membership in understanding their role and in implementing initiatives at the local level.

B. N4A's Approach in Achieving Goals and Objectives

N4A will again utilize the Board Committee approach to achieve the agreed upon goals and objectives. Following is a list of the N4A Committees with proposed activity items:

1. Long Term Care Committee

(Proposed name change: Continuum of Community Based and In-Home Care Committee)

Proposed Activities:

a. Develop N4A membership statement regarding role of Area Agencies and the Network on Aging in the Continuum of Community Based and In-Home Care program initiatives.

b. Identify barriers (legislative, attitudinal, economic, demographic, political) to achieving the Continuum of Care program implementation.

c. Identify Area Agency resources needed to implement the Continuum of Care program initiatives:

- Personnel
- Structural (designation)
- Public resources
- Private/voluntary resources, including family supports

- Private/corporate resources

d. Develop guidelines for Area Agency responsibilities and resources (criteria project)

e. Establish priority technical assistance areas where AoA and other federal discretionary resources should be focused - providing input to the KPA workgroup activities.

f. Set forth specific role private voluntary and corporate sector might assume in future Continuum of Care initiatives.

g. Identify key linkages with other public and private programs and service delivery systems that should be established as well as barriers to such linkages.

h. Identify and prioritize N4A initiatives that should be undertaken which will assist Area Agencies in implementing the Continuum of Care concept.

Products:

Long Term Care Technical Assistance Manual, N4A Mission Statement, Area Agency Criteria Project Paper.

2. Advocacy/Advisory Council Committee

(Proposed name change: Advisory Council/Leadership Committee)

Proposed Activities:

a. Develop brochure on the role of Area Agencies on Aging in the Network on Aging.

b. Develop technical assistance materials on effective Advisory Council linkages between the community and Area Agencies.

Richard Winchell

Rather than suggesting what we can do for the aging, Mr. Winchell proposed legislation which would enable each of us to provide for our own retirement.

He posed the question of how can the average person, indeed, how can the average pension fund save and invest for retirement?

The State could pass a law that regulated South Carolina utilities of all kinds to earn an average real return of 7 percent on investment. A real return is a return in addition to inflation--if the inflation rate last year was 12 percent, then the PSC should be legally bound to grant water, phone and power rates to yield an actual 7 plus 12 = 19 percent return on investment for next year.

What is unique about utilities that they are best suited to be made the vehicles for savings and investment for retirement? In his opinion, there are three factors:

1. Utilities are ubiquitous and capital intensive. They can put these monies to good use by increasing efficiency, and the expenditures would probably combat inflation.

2. Utilities are regulated. All that needs to be done is to set rates which allow a fair return on investment and then police the utilities that all expenses are legitimate and that they operate efficiently.

3. The costs would be relatively small and payable monthly. Each ratepayer can control his own cost--as much as he is willing to pay for. By paying a little more on the power or phone or water bill, it can mean a healthy pension at retirement.

(Complete statement on the following pages).

Senator Rubin asked Mr. Winchell if he is retired.

Mr. Winchell replied no he is not, he is just worrying about it. He has been asking himself in what to invest, but has not found it.

Senator Rubin wanted to know if the utilities are not making a 7 percent return on their investments now.

Mr. Winchell explained not a real return. SCE&G, for example, is talking about allowing 17 percent, if you subtract last year's 12 percent

inflation, that would be 5 percent return on investments.

Senator Rubin remarked that the return on utilities' stocks is better than 7 percent at the present time.

Mr. Winchell replied that we are talking about return, not investment. The price of utility stocks is below book value and going down.

To: S.C. STUDY COMMITTEE ON AGING 9/21/81

From: L. Winchell

Subject: REMARKS PLANNED FOR SEP. 24, 1981 HEARING

The time limit forces these remarks to be fewer than my written ones. Rather than suggesting what we can do for the aging - a group which includes all of us - I propose legislation enabling each of us to provide for his own retirement.

No longer has the average person or the average pension fund a safe way to save and invest for retirement. I propose that we legislate a private enterprise way.

We have been hearing that we cannot rely upon Social Security.

In recent years, the average pension fund has been earning a lower return on investment than the inflation rate. This includes our S.C. Retirement System, of which many of you are members. For any company or pension fund to earn a lower return than the inflation rate is for that company or pension fund to LOSE money, in terms of dollars of constant value. If the average pension fund does not do something different, where is the money for pensions going to come from, in a few years?

Similarly, how can the average individual safely save and invest, now, for his own retirement?

We used to be able to count on savings accounts, U.S. Savings Bonds, and utilities. Inflation has wasted those vehicles for savings.

Are gold, silver, diamonds, and collectibles going up, or down? They yield no income. How does one save them safely, for years?

Are stocks, in general, a good investment for the average person who is trying to save for his retirement? As I type this, the stock market is at a 15 month low, having fallen from over 1000 to about 850 in the last 90 days or less. One can't be assured he is buying a Haloid (which became Xerox) or an IBM. One might be buying a Penn-Central or a Chrysler: who would have thought these giants would fail?

Bonds have been a losing investment for years. The yields have been so low that the prices have dropped. Bonds are responsible for the low returns on the S.C. Retirement System funds, for at least the past 5 years.

Real estate apparently can be a good investment, but does the average person know what property to invest in? And usually real estate requires chunks of money, whereas most of us can save only a little at a time. Further, if everyone who wanted to save invested in real estate, the demand would drive the prices up, worsening inflation. Then the successful bidders for rental real estate would have to increase their rents, to get a fair return on investment, exacerbating inflation.

Savings institutions pay less than the inflation rate.

We don't know whether money market funds are ephemeral - as REITs were, during the 70's - or whether they will always yield more than the inflation rate. Is the average person able to invest in money market funds?

How can the average person - indeed, how can the average pension fund - save and invest for retirement?

Ideally, I'd like merely to leave the question with you all for awhile, for then I would either get a good answer - which I could use for my own pension planning -

or you would agree that the problem is a tough one. If you found the problem a tough one, you would be less likely to dismiss my proposal as being quixotic. As legislators and businessmen, I suspect you have had much experience at wrestling to solve a problem, only to be rewarded with criticism by the news media or constituents or employees who do not have a better solution but are SURE that ". . . there must be a better way". It is always far easier to criticize than to propose.

However, my situation with you is not ideal. If I leave the question with you, I suspect it will quickly be superceded by something else of a more immediate nature and capable of more ready solution. So I will simply repeat the question, hoping that you will hear it, and then consider my proposal. The question is: HOW CAN THE AVERAGE PERSON, OR THE AVERAGE PENSION FUND, SAFELY SAVE AND INVEST FOR RETIREMENT ?

Before I propose a solution, I point out that if the average person and the average pension fund do not have a safe way to save and invest for retirement, it follows that the average person will not have a way to support himself in retirement. In our country, we won't let the average retiree suffer - right ? - so that means that one way or another - food stamps, subsidies, welfare, Social Security, or government pensions - the average worker is going to be expected to support the average retiree. However, I read that the demographics are such that, within about 3 decades, the work force will have only two persons for each retiree. We dare not expect that each working person will support himself and his family, support government, and also support half of a retiree, do we? So we have to provide a way that the average person can save and invest safely for his own retirement.

It seems to me we can LEGISLATE a way into existence, and then promote it.

Our state could pass a law that regulated S.C. utilities (of all kinds) are to earn an average REAL return of 7% on investment.

A real return is a return IN ADDITION TO INFLATION: if the inflation rate last year was 12%, then the PSC should be legally bound to grant water, phone, and power rates to yield an actual 7 plus 12 or 19% return on investment for next year. If any company falls below 19% ROI for the next year, the difference would be made up in the subsequent year. If any company exceeds 19% ROI, the difference would be made up in the subsequent year.

The PSC would continue to police the efficiency of utilities and the legitimacy of utilities claimed expenses.

With passage of such legislation, utilities could once again become the "stocks for widows, orphans, and pensions funds", which they once were, and everyone would have at least that way to invest and save for retirement.

Corollary benefits would include increased stability and efficiency of S.C. utilities. For example, if S.C. utilities were assured a 7% real return on investment, they would be able to attract capital to improve service and increase efficiency, and would be able to reduce fuel costs and dependance upon foreign oil. Power companies could convert various oil-buring facilities to less expensive fuels, and would have R & D funds to experimentwith alternative sources of energy we keep hearing about.

What is unique about utilities that they are best suited to be made the vehicles for savings and investment for retirement? My response is this unique combination of factors:

1. Utilities are ubiquitous and are capital intensive. Being everywhere and needing huge amounts of capital, they can readily and efficiently

absorb the large amounts of money required for individuals and pension funds to save for pensions, and can put those monies to good use without causing distortions in our economy. Since the monies would be used to increase efficiency, the expenditures would probably combat inflation.

2. Utilities are regulated. We would not be writing "blank checks" to a non-regulated industry.

All we need do is set rates which allow a fair return on investment (7% plus the past year's inflation rate) and then police theutilities to be sure all expenses are legitimate and that utilities operate efficiently .

A mere 7% ROI is not going to make a few rich at the expense of the many.

3. The costs would be relatively small and would be payable monthly.

Obviously there will be costs in providing means for private, corporate, and public pensions: there is no "free lunch". But the cost to each ratepayer can be controlled by that ratepayer: each uses only as much as he is willing to pay for.

The exchange - everyone's paying a little more on his power bill or his phone bill or his water bill - so that everyone has a safe way to save and invest for retirement - accommodates the "fallacy of democracy": the costs are diffuse; the benefits are concentrated. That is, each person could say to himself,"I pay a little more on my bills, each month, but it will mean a healthy pension to me when I retire." People are willing to pay when it is clear that they get their monies' worth.

NOTES AND COMMENTS:
TO SUPPLEMENT REMARKS BY R. WINCHELL TO S.C. STUDY COMMITTEE ON AGING

NOTES

A References indicating that many pension funds have been earning a lower return on investment than the inflation rate.

1. Public

   a. WALL STREET JOURNAL, Aug. 26, 1981, page 45
   b. THE COLUMBIA RECORD, "The LIVE Wire", Sep. 2, 1981, page 2
      (quoted Mr. Purvis Collins about the S.C. Retirement System)

2. Private

   a. WALL STREET JOURNAL, April 10, 1981, page. 45
   b. WALL STREET JOURNAL, July 2, 1981, page 42
   c. NEWSWEEK magazine, June 1, 1981, pages 24 and 28

B. Example showing how a return on investment equal to the inflation rate results in a LOSS in buying power:

A pension fund buys a $10,000 bond	$10,000.
The bond yields 10% or	1,000. a year
So at the end of the first year, pension fund	$11,000. SUM

However, because of 10% inflation, each $1 invested now has the buying power of only $0.90.

Therefore 0.90 ($11,000) is only $9900.
So the pension fund has LOST 100. in buying power

COMMENTS: Examples of how $1 invested at the beginning of each year would grow into a pension fund at 7% (first two columns). The third column shows how much one could expect each year for 20 years at 7% if he had paid $2000 a year into an IRA at 7% for the number of years in the first column. The fourth column breaks the third column down to monthly payments.

AT END OF YEAR	CUMULATIVE VALUE OF SERIES OF $1/YR. PMTS	PENSION PAYABLE FROM $2000/YR. FOR 20 YRS. PAID INTO AN IRA AT 7% FOR NUMBER OF YEARS SHOWN IN FIRST COLUMN	
		$/YR. FOR 20 YRS.	$/MO. FOR 20 YRS.
1	1.07	101.	8.
2	2.21	209.	17.
5	6.16	325.	27.
10	14.75	1395.	116.
15	26.89	2538.	212.
20	43.87	4141.	345.
25	67.68	6388.	532.
30	101.07	9540.	795.
40	213.61	20163.	1680.

For example, if one paid $1000 a year into an IRA earning a real 7% for 30 years, one would have accumulated $101,070. If one left that $101,070. invested at 7%, one could draw $4770 a year (or $397.50 a month) for 20 years.

Josie K. Claiborne
General Counsel/Project Director
Aging Program
Columbia Urban League, Inc.

Action needs to be taken on two items:

1. Monitoring of the new Medicaid Rules and Regulations. Limitations of four prescriptions per month, 18 doctor's visits and 12 days in the hospital per year, may prove to be hazardous for some persons who have a combination of medical conditions.

2. The Committee should undertake a feasibility study to have a State supplement to SSI to balance the reductions in many of the benefit programs.

(Statement follows).

Presentor: Josie K. Claiborne
Columbia Urban League's Aging Program

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, LADIES AND GENTLEMEN:

I COME BEFORE YOU TODAY AS A PERSON CONCERNED WITH THE PLIGHT OF THE ELDERLY IN SOUTH CAROLINA AS ONE WHO WORKS WITH ELDERLY PERSONS ON A DAILY BASIS AND AS AN ADVOCATE FOR THE RIGHTS OF THE ELDERLY.

DAILY THE PHONE IN OUR OFFICE RINGS AND WE HEAR THE QUESTIONS FROM OUR CLIENTS: "ARE THEY REALLY GOING TO CUT OFF MY SOCIAL SECURITY?", "ARE THEY GOING TO CUT OFF MY FOOD STAMPS - I ONLY GET $10.00 WORTH NOW?" , " IS THE GOVERNMENT GOING TO STOP HELPING ME WITH MY RENT OF HOUSE PAYMENTS?" , "WHERE WILL I GO IF I CANT LIVE IN MY HOME ANYMORE?". THEIR PRIMARY CONCERN IS THE UNCERTAINTY OF THEIR IMMEDIATE FUTURE.

ECONOMIC BAD TIMES FRIGHTEN THEM NOT BECAUSE THEY ARE NOT FAMILIAR WITH BAD TIMES, BUT AS ONE CLIENT SAID: " IT WAS BAD ENOUGH WHEN I HAD TWO STRONG LEGS, TWO STRONG ARMS, A GOOD BACK, AND A QUICK MIND -- BUT NOW I DONT HAVE THOSE THINGS AND I DONT THINK I CAN FIGHT BACK AND STRUGGLE LIKE I USED TO."

THE BASIC QUESTION THAT I ENCOUNTER EVERYDAY IS "WHAT AM I GOING TO DO?" MY ONLY REPLY TO THEM IS TO PRAY AND HOPE FOR THE BEST, TO RAISE HOLY HELL WITH THE PEOPLE WHO ARE ELECTED TO REPRESENT THEM, AND TO BE PREPARED TO RIDE TO THE POLLS IN A WHEEL CHAIR IF THEY MUST TO EXPRESS THEIR APPROVAL OR DISAPPROVAL WHEN ELECTION TIME ROLLS AROUND AGAIN.

HOWEVER, I WOULD LIKE TO DO MORE THAN OFFER THEM PLATITUDES AND ENCOURAGING WORDS AND I THEREFORE CALL UPON YOU TODAY NOT TO FORGET ABOUT THOSE PERSONS WHO NEED THE GREATEST AMOUNT OF ASSISTANCE. WHEN I READ THE TWELFTH ANNUAL REPORT OF THE COMMITTEE TO CONDUCT CONTINUING STUDIES OF PUBLIC AND PRIVATE SERVICES, PROGRAMS AND FACILITIES FOR THE AGING, I WAS HEARTENED THAT PROGRESS HAS BEEN MADE AND I AM HOPEFUL AND CONFIDENT THAT MORE PROGRESS WILL BE MADE .

I WOULD LIKE TO CALL ON THIS COMMITTEE TO DO TWO THINGS:

(1) THE NEW MEDICAID RULES AND REGULATIONS WHICH WILL GO INTO EFFECT NEED CONSTANT MONITORING TO INSURE THAT THEIR IMPLEMENTATION WILL NOT CAUSE MORE UNDUE HARDSHIP THAN IS ABSOLUTELY AND TOTALLY NECESSARY. LIMITATIONS SUCH AS FOUR PRESCRIPTIONS PER MONTH, EIGHTEEN DOCTORS OFFICE VISITS AND TWELVE DAYS IN THE HOSPITAL PER YEAR WITHOUT EXCEPTION AND ACROSS THE BOARD, REGARDLESS OF MEDICAL CONDITION POTENTIALLY COULD BE TOO SEVERE FOR SOME PATIENTS AND NOT JUSTIFIED BY THE SPENDING LIMITS ANTICIPATED. A FAIRLY COMMON MEDICAL CONDITION OF A DIABETIC PATIENT WITH A SEVERE HEART PROBLEM NORMALLY REQUIRES MORE THAN THE ABOVE. THE SELECTION AMONG THE NORMAL SIX OR SEVEN LIFE-SAVING DRUGS COMMON WITH THESE CONDITIONS IS A KIND OF RUSSIAN ROULETTE WHICH NO PERSON SHOULD HAVE TO PLAY , FOR EXAMPLE.

(2) THIS COMMITTEE SHOULD UNDERTAKE TO STUDY THE FEASIBILITY OF INSTITUTING A STATE SUPPLEMENT TO SSI TO REPLACE THE REDUCTIONS IN MANY BENEFIT PROGRAMS. DIRECT CASH ASSISTANCE COULD BE A MORE COST EFFECTIVE WAY TO IMPROVE THE CONDITION OF OUR NEEDIEST ELDERLY CITIZENS WITHOUT THE IMPLEMENTATION OF A MYRIAD NUMBER OF NEW PROGRAMS AND IDEAS.

THERE IS LITTLE NEED TO CATALOG THE GENERAL NEEDS OF THE ELDERLY IN SOUTH CAROLINA. THE PRELIMINARY FORUMS LEADING TO THE WHITE HOUSE CONFERENCE HAVE DONE AN EXCELLENT JOB OF PRESENTING MANY OF THE CONCERNS OF THE ELDERLY TO THE PUBLIC AT LARGE. HOWEVER, IN THESE TIMES OF DWINDLING RESOURCES AND INCREASING DEMAND FOR SERVICES, ALL STEPS MUST BE TAKES TO INSURE THAT THE TRULY NEEDY ARE NOT FORGOTTEN.

WE MUST DO WHAT WE CAN TO RELIEVE THEIR ANXIETIES AND CONCERNS ABOUT THE GOVERNMENTS COMMITTMENT TO ADDRESSING THE NEEDS OF THOSE WHO CANNOT MEET THEIR NEEDS THEMSELVES.

THANK YOU.

Mr. Michael D. Byrd
Administrative Program Analyst
Division of Home Health Services
Department of Health and Environmental
Control

This Agency provided home health services to 11,000 South Carolinians aged 65 and older in FY 1981. Half of these were 75 years old or older. They emphasize the role of home health services in the prevention of needless institutionalization.

He projected that in FY 1982 DHEC will provide 9 percent more home health visits than were made in FY 1981. This will come about by stressing the importance of cost containment and productivity of their staff and further DHEC's Home Health Services operates primarily on earned funds. As long as Medicare and Medicaid do not decrease their coverage of home health services, decreases in State funds do not have the same impact on DHEC's Home Health Services Division as it does on other agencies.

This Agency's policy on long term care would support the expansion of community-based services and, also, provide assistance for families who care for older and disabled persons at home. They would be supportive of redistribution of present funds so that more in-home services could be provided.

Mr. Byrd presented the following recommendations:

1. State Tax Credits to persons who support relatives aged 65 or older in their homes.
   He referred to a new law in Idaho which allows $1,000 tax deduction to individuals who maintain a relative 65 years or older in the home. Utah and Wisconsin are studying the feasibility of tax credits.
2. The Long Term Care Council, Study Committee on Aging and DSS should apply for a waiver, approved by the Secretary of Health and Human Services, which would allow states to provide non-medical home care services to Medicaid beneficiaries in lieu of institutional care.
3. Grant an exception or establish a different category of state position for caregivers employed on earned or Federal funds.

Mr. Bryrd's statement, which is on the following pages, notes that these are not official positions of the Department since they have not been approved by the DHEC Board.

Dr. Parrish asked to have an explanation in what categories these services were which were provided to the 11,000 people.

Mr. Byrd explained that they provided about 320,000 home health visits to these persons in their homes. These are people who can not leave their homes, except with undue stress on them or to seek medical care. The services of a registered nurse, a home health aide, a homemaker, physical or occupational therapist or a medical social worker are provided. All of these people are trained to administer to the aging in their homes.

Dr. Parrish thanked him for the explanation which provided a clear picture of the services which Mr. Byrd's Department offers.

Senator Rubin recognized Mr. Bill Bradley, State Ombudsman, acknowledging the great job he is doing.

Presentation by Michael Byrd to the Joint Study Committee on Aging, September 24, 1981

Senator Rubin, members of the Joint Study Committee on Aging, distinguished guests.

My name is Michael Byrd and I represent the Bureau of Home Health Services of the Department of Health and Environmental Control. In Fiscal Year 1981, our agency provided home health services to 11,000 South Carolinians aged 65 or older. Over half of these 11,000 persons were 75 years old or older. We share your concerns for the welfare of our state's older citizens. We appreciate this opportunity to speak to you about the needs of the persons we serve. The support of this committee has been instrumental in implementing previously requested measures such as increased funding for home health services for the medically needy, licensure and Certificate of Need requirements for home health agencies, and appropriation of Title XX match for Health Support.

We justified our past recommendations by emphasizing the role of home health services in the prevention of needless institutionlization of the state's older citizens.

This coming year there may be no additional state dollars even for worthwhile projects such as home health services. We do want to share with you what DHEC is doing to make our present funding go further and we would like to suggest some ways to stretch the state dollars now spent for long term care.

In Fiscal Year 82 we are going to do more with proportionately less state funding. DHEC will provide 9% more home health visits than were made in FY 81. There are several reasons we will be able to do this. First of all, DHEC's home health services has always stressed the importance of cost containment and productivity of our staff. While the charge for a home health visit increased this year by 7%, this is well below the annual rate of increase of most other prices, especially health care services. Secondly, DHEC's home health services operates primarily on earned funds. As long as Medicare and Medicaid do not decrease

their coverage of home health services, decreases in state funds do not have the same impact on DHEC's home health services as it does on some other agencies.

1. State Policy on Long Term Care

Our agency advocates a state policy on long term care services which would support the expansion of community-based services and provide assistance for families who care for older and disabled persons at home. This policy should allow for expansion of state agencies which provide community based services but are not dependent on state funds to finance these services. This policy would not necessarily increase the level of state funding for long term care but would redistribute present funds to provide for more in-home services.

Specific recommendations are as follows:

2. State Tax Credits to Individuals Who Support an Immediate Relative Aged 65 or Older in the Household

Family and friends provide much of the daily care and support for home health patients. DHEC's average charge for services to Medicaid patients is $628 per patient per year. This is well below the Medicaid cost per patient per year for nursing home care. However, the $628 includes few of the expenses incurred by the patients who elect to remain at home instead of seeking nursing home care. In addition to the responsibility of care that families have to manage, there are additional expenditures for food, shelter, and clothing. The difference in the cost of in-home care and the costs of nursing home care is that the state and federal government bear most of the costs of Medicaid financed nursing home care. Some states are recognizing that families that elect to care for a relative at home are saving them money. A new law in Idaho allows a $1,000 tax deduction to individuals who maintain a relative 65 years old or older in the household. Utah and Wisconsin have approved bills commissioning studies of the feasibility of tax credits for taxpayers maintaining an elderly person in the home.

Recommendation: The Joint Study Committee design a plan to ease the financial burden on families caring for elderly persons at home.

3. Medicaid Community Care Act

The Omnibus Reconciliation Act of 1981 includes the major provisions of the Medicaid Community Care Act which would allow states to provide non-medical home care services to Medicaid beneficiaries in lieu of institutional care under a waiver approved by the Secerteary of Health and Human Services.

Recommendation: The Long Term Care Council, the Joint Study Committee, and DSS should apply for this waiver.

4. Effect of State Personnel "Head Count" on Services for the Elderly

The location and service capacity of other home care providers has not diminished the statewide need for DHEC's services. Appropriate and increased use of home health care in reducing hospital stays and delaying institutionalization has increased demand for services. The "head count" effectively limits our resources to provide essential care of the sick at home.

The Long Term Care Project in Spartanburg, Union and Cherokee Counties and its statewide expansion to perform reviews once performed by PSRO will identify additional people in need of services. Hospice programs, both community and hospital-based, contract with the health departments to provide the home health care portion of their programs. If state agencies, including DHEC, are not able to increase direct caregiver staff to meet these increased demands for service, the result will be institutionalization and waiting lines.

Recommendation: That the Legislature consider granting an exception or establishing a different category of state position for caregivers employed on earned or federal funds.

I appreciate very much the opportunity to speak to you today. I will answer any questions you may have.

Note: These are not official positions of the Department since they have not been approved by DHEC Board

Mr. John Zuidema, President
S. C. Federation of Older Americans
Columbia, SC

Mr. Zuidema spoke on a project known as "Senior Forums for Progress." The purpose of this project, which is funded through a mini-grant from ACTION, is to involve senior citizens in efforts to solve problems they are faced with in these times. Seven regional forums with the help of over 500 volunteers have been conducted to date. By the end of October, they anticipate that all ten regional planning districts will have conducted a "Forum for Progress," and the next step will be the planning and conducting of forums at the county level. The forum participants have studied and discussed the findings of the State White House Conference on Aging held in Columbia in May of 1981, with the emphasis on what local, State government and the private sector can do to assist the elderly. Local and State Government will be asked to participate in "reverse revenue sharing," i.e. to assume more of the Federal share of programs.

He identified March 3, 1982, as the target date set for "Senior Citizens' Day with the Legislature." He asked that the Committee introduce a Resolution which would designate March 3, 1982, as the day when the General Assembly will host a group of about 500 older South Carolinians.

(Mr. Zuidema's statement is on the following pages).

TESTIMONY OF:

JOHN ZUIDEMA
President

SOUTH CAROLINA FEDERATION OF OLDER AMERICANS

Presented to the South Carolina Joint Legislative Governor's Committee on Aging.

September 24, 1981

Senator Rubin and other committee members. Thank you for the opportunity to speak to you today.

I am John Zuidema, President of the South Carolina Federation of Older Americans.

The Federation was founded in 1971 by Dr. Wil Lou Gray and other prominent South Carolinians who were concerned about the needs of the elderly. Ten years after its founding, the Federation can look back with pride on the impact it has made on the well being of our state's senior citizens. We are particularly proud of the role we have played in coordinating the statewide Legislative Forum and of the cooperative relationship which exists between the Forum and the Legislative Committee on Aging.

In the spring of this year, the South Carolina Federation of Older Americans received a mini-grant from ACTION for the purpose of involving senior citizens in efforts to solve some of the unique problems which they face in these difficult times. The project is known as "Senior Forums for Progress".

As of this date over five hundred volunteers, many of them over age 55, have participated in planning and conducting seven regional forums. When we use the term "regional", we are describing the ten regional planning districts.

By the end of October all ten regions will have conducted a Forum For Progress. The next step is the planning and conducting of forums at the county level.

In all instances the forum participants have carefully studied and discussed the findings of the State White House Conference on Aging held at Columbia College in May of this year. In reviewing these proceedings, emphasis has been placed on what local and state government as well as the private sector could do to assist the elderly.

As you are too well aware, this is not the time to look to the Federal Government for additional resources. In fact, it seems that state and local governments are being asked to participate in "reverse revenue sharing". That is, to assume more of the federal share of program costs.

As an example The Federal Administration on Aging has been providing about $70,000 a year to the State Commission on Aging to help provide badly needed training for persons who provide services at the local level to the elderly.

On Monday of this week the Commission Staff were informed that instead of the $69,000 requested for FY '82, that the sum of $12,000 would be provided. This is 17% of what was requested! An outstandingly efficient and effective training program has been decimated by Federal action! The elderly will suffer.

I would like to return to The Senior Forums for Progress to describe a very exciting development. As a result of discussions among the various persons involved in this project, it was decided to try to bring senior citizens to Columbia next year to learn about the legislative process and to have visits with members of their local Legislative Delegations.

A Steering Committee chaired by Dr. J. Obert Kempson of the South Carolina Department of Mental Health was formed to begin preliminary planning for this occasion. They have met several times and now feel that "Senior Citizens' Day with the Legislature" can become a reality if the Legislature will agree to the concept. The committee has identified March 3, 1982, as a target date.

On behalf of the Steering Committee and the Board of Directors of The Federation of Older Americans, I am respectively requesting that the Legislative Committee on Aging help make this day a reality. You can do so by introducing the appropriate resolution which would designate March 3, 1982, as the day when the General Assembly will host a representative group of older South Carolinians.

It is anticipated that over 500 seniors would attend this event and that much public attention will be focused on this day.

Thank you.

Dr. Hilda K. Ross, Director
Mental Health Services for the Aging
Department of Mental Health
Columbia, SC

With the increasing number of elderly people projected for South Carolina in the next ten years and the home becoming less of a primary care resource, the need for increased numbers of adult day care centers as well as residential care facilities will have its impact on the community, the mental health centers and all the divisions and hospitals within the Department of Mental Health.

Of critical need to families who do care for elderly at home is a roster listing services available to these families; this would greatly sustain them in their supportive roles.

Dr. Ross' office is involved in a number of various services and projects:

1. Assessing a newly improved discharge process
2. Developing support groups for families caring for the elderly at home
3. Finding alternatives to the emergency commitment laws
4. Exploring alternative housing arrangements
5. Projecting the creation of Tucker Center as a teaching nursing home

The larger problem for the Department of Mental Health, as it affects the elderly, regards the provision of services for the chronically mentally ill. This group will be discharged from State hospitals into the communities. To effect this, the Department of Mental Health declared 1981-1982 a Planning Year. All patients in their State psychiatric hospitals will be assessed. so that the number of people who can be discharged and the services they will need can be projected. The chronically mentally ill are described as people who are "poor, lacking in social graces and who are not perceived by society as pleasant to work with." So these are the people who may need community placement and programs. The Department of Mental Health and the Community Mental Health Centers are asking for community understanding and help in achieving this goal. As one mental health specialist, who spends eight hours a day on a ward, said, "they can be returned to the community; all they need are people who will talk to them, touch them, and believe in them."

At a recent conference which Dr. Ross attended, Dr. John Talbott, Professor of Psychiatry at Cornell Medical School, pointed out "people

support is more effective than programs based primarily on service attention."

In closing, Dr. Ross said that her Department is gratified to have the broad-based support of the Study Committee on Aging.

Senator Rubin referred to Governor Riley's letter, which was read in the morning session, indicating that within the next few weeks a "Resource Panel" will be created. The purpose of this Resource Panel will be to discuss the future needs of the elderly in South Carolina. What Dr. Ross proposed would contemplate a substantial investment, and Senator Rubin suggested that she and Ms. Suzanne Lewis, Liaison from the Governor's Office, work on this together.

South Carolina Department of Mental Health
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PUBLIC HEARING - September 24, 1981

STUDY COMMITTEE ON AGING

Hilda K. Ross, Ph...
Director, Mental Health
Services for the Aging

Senator Rubin and the members of the Study Committee On Aging are to be commended for giving our community and the Office of Mental Health Services for the Aging in the Department of Mental Health the opportunity of a public hearing.

Everyone in the field of aging is fully aware of the increased numbers of elderly people 75 years and older who are projected for South Carolina, from 40,423 in 1980 to 132,195 by 1990, representing a 46% increase. Implications for levels of residential care, physical and mental health services, families caring for elderly and the necessary services for this aging population clearly will have its impact on the community, the mental health centers and all the divisions and hospitals within the Department of Mental Health. As more women enter the job market, the home becomes less of a primary care resource for this very elderly population and this development will impact on the need for increasing the numbers of adult day care centers and a range of skillfully managed and supervised residential care facilities. Where we do find families caring for elderly at home, a roster of services aiding these families is critical if we are to lengthen and sustain their supportive roles.

With this in mind, this Office is involved in a broad variety of service, training, and research projects which include: assessing a newly improved discharge process, developing support groups for families caring for the elderly at home. It continues its activity in finding alternatives to the emergency commitment laws. The Department is currently exploring alternative housing arrangements and is actively involved with other state and local agencies in seeking creative solutions to common problem areas. Dr. Charles Still, the

new Deputy Commissioner of long term care is projecting the creation of Tucker Center as a teaching nursing home. Institute training for clinical, administrative and social services personnel has important implications for every nursing home and their almost fourteen thousand patients (9/8/81 - DHEC), and keeping in focus the burgeoning very elderly population, the State plans for the Spartanburg long term care project to become statewide.

The larger problem for the entire Department of Mental Health, as it affects the elderly, concerns the provision of services for a handicapped group also identified as the chronically mentally ill who will be discharged from state hospitals into the communities and neighborhoods. The swelling admission rates and very tight budgets compel the decision to reexamine the appropriateness of hospital placement and properly implies a redirection of attention from an unalterable institutional placement to appropriate residential care in the neighborhood. To effect this, the Department of Mental Health declared 1981-82 a Planning Year. All patients in our state psychiatric hospitals will be assessed. This information will provide a data base for projecting the numbers of people who can be discharged to our communities and what services each person will need. Community services need to be in place prior to their discharge. The block grants submitted by the SCDMH specifically address the elderly handicapped and the services they will require through the community mental health centers.

Now, who are these handicapped people we call the chronically mentally ill whom we expect to reintegrate into the community? What are they like? What do we mean when we say chronically mentally ill? At a symposium in Albany, Psychiatrist Dr. Gary Miller defined the Chronically Mentally Ill as individuals who are usually - 1) Poor. 2) Without supporting family members or close friends. 3) People who are shy, awkward, passive, dependent, socially ill at ease, and in some few cases, aggressive in a way which

embarrasses or frightens people. 4) They lack basic survival skills necessary to cope in our society. 5) They are usually unattractive in appearance because of poor personal hygiene and suitable clothing. 6) They cannot transport themselves easily. 7) They lack dental care. 8) They are deficient in communication skills. 9) They are without adequate housing, little or no cash and lacking in skills to handle it. 10) Many are nutritionally deficient. In sum, "chronically mentally ill" is a euphenism for people "who are poor, lacking in social graces and who are not perceived by society as pleasant to work with".

These are the increasing numbers of hospital-placed people who may need community placement and programs where they can be maintained indefinitely. Neither the Department of Mental Health nor the Community Mental Health centers can achieve this transition alone. It is here that we need community understanding and help to achieve reintegration.

We invite continued cooperation from our "sister" agencies, assistance from the well-elderly, the schools, the churches, the existing families and friends. As one mental health specialist, who spends eight hours a day on the ward, stated, "they can be returned to the community; all they need are people who will talk to them, touch them, and believe in them". We are asking for the belief that community nurturing can improve function.

I am here to make a very special request -- a request for understanding and support of this special population. The handicapped need the assistance of people who can help improve their quality of life and outlook by helping them reestablish a network of friends. We, as professionals and service providers, have to help people in our community accept, understand and support the chronically mentally ill who may be living near them in their neighborhoods.

We want to be efficient as possible in developing community service programs and yet realistically we know that without an accompanying supportive community, the desired outcomes will not be realized. Dollars alone will not suffice. Right now the Department of Mental Health is looking at funds going into treatment and with facts in hand, where monies will be needed. The acceptance of these individuals, without fearing them, coupled with forthright concern for their improvement, will make the meaningfulness of whatever dollars we spend become apparent.

In closing, I want to share with you that at national conferences, there is much discussion for the development of people-support for the chronically mentally ill in the neighborhoods. As Dr. John Talbott, Professor of Psychiatry at Cornell Medical School, pointed out recently at a conference I attended in Washington, "people-support is more effective than programs based primarily on service attention". In view of demographics for the elderly population, the efforts of other agencies and the Department of Mental Health in the field of long term care, and in the community reintegration of "the poor, the people lacking in social graces", we are gratified to have the support of the Study Committee on Aging.

Thank you.

Hilda K. Ross, Ph.D.

HKR:fm

September 24, 1981

Mr. Marvin Lare, Executive Coordinator
Community Care, Inc.
Columbia, SC

Mr. Lare spoke on the progress, plans and potentials of the Care Coordination for the Health Impaired Elderly Project and asked for the Committee's support and involvement for the benefit of the people of this State.

In a brief background summary, Mr. Lare explained that South Carolina was one of eight states which received a million dollar grant from the Robert Wood Johnson Foundation. This funding which started in February of 1980 --for a five-year period--is for the establishment of a model coordinating unit in the coordination of services for the health impaired elderly.

The Project's goal is to develop a means by which all long term care resources can be coordinated to be most effective in meeting the needs of health impaired persons. A prerequisite to reach this goal is, of course, for the different health care, social services and mental health agencies to communicate and work together. Attached to his presentation is a listing of about 20 agencies and institutions from Richland and Lexington Counties who participate in this goal.

During the first year, 200 clients were assessed by Project staff. In the second year, first year's learnings were reviewed, current problems identified, the future impact of an aging population projected, and plans made to develop a uniform way to assess their clients and coordinate case management and services.

Since then, the following has been accomplished:

1. A Uniform Assessment Process has been developed.
2. A User's Manual has been developed and Project staff have trained 600 people in the participating agencies to use this process.
3. A Client Information System has been established. Each worker sends a copy of his/her assessment and plan of care to the Project office to keep track of what services have been or need to be performed.
4. The Natural Supports of family, friends, etc. is not being ignored. Caregivers was the major factor for Community Care to become involved in the Project. These Natural Supports are developed and strengthened through two fask forces:

a) Consortium for the Impaired and their Caregivers (CIC). This is composed of agencies and professionals who plan and design resources to assist caregivers of the homebound impaired person.

b) Task Force on volunteers working with the elderly and impaired persons. This Task Force has held a workshop to train these volunteers.

In addition, the Project is defining a new position for a Community Resources Developer to develop ways of better utilizing the Natural Supports.

Plans for the future include:

1. Formation of small demonstration clusters to design and perfect Coordinated Case Management processes.
2. Plans for regular follow-up and review will be arranged in these processes.
3. The Project's Community Advisory Council will hold its first Community Leaders Briefing Day in mid-November. This will insure making the community aware of the needs in the long term care field and its progress in how to meet the needs.

Longer range plans are:

1. Evaluation and revision of the processes developed during 1982.
2. Preparation for their independent functioning the following year.
3. Perfection of the model for use elsewhere.

Many immediate direct benefits to clients, the formal system, and the Natural Supports in the Project area are anticipated and to achieve this, the Project is working closely with State as well as local agencies. Reports have been made to the S. C. Commission on Aging and the Long Term Care Council.

Senator Rubin thanked Mr. Lare for this good progress report and wanted to know if the Robert Wood Johnson Foundation is satisfied.

Mr. Lare confirmed their satisfaction and added that he feels they are the Foundation's leading project, out of the eight that were funded, and they are themselves pleased with the progress.

Senator Rubin asked if the Foundation would undertake any long term funding or just pilot projects.

Mr. Lare replied that the Foundation realizes that the coordination of services is a long and complex process, so their commitment is anticipated to run five to six years.

Senator Rubin questioned if they coordinate with private groups and churches.

Mr. Lare confirmed that a part of the focus on community and natural supports is looking to churches, community groups as well as families and friends as being one of the most basic resources. One of their goals is the effective meshing of this with a formal system in a coordinated and complementary manner.

Senator Rubin suggested that they will have to emphasize this area much more in the future because government can not continue to carry it all.

Mr. Lare agreed and stated that this is a low overhead approach to coordination, to take what is existing and making the best utilization between and among agencies.

Senator Rubin asked Mrs. Bumgardner, who is on the Advisory Council, if she wanted to add something to this.

Mrs. Bumgardner expressed her appreciation to represent the Committee on the Council. She feels that we learn from it and, hopefully, can contribute as well.

TESTIMONY
TO
THE STATE OF SOUTH CAROLINA
STUDY COMMITTEE ON AGING
BY
MARVIN I. LARE
PROJECT EXECUTIVE
CARE COORDINATION FOR THE HEALTH IMPAIRED ELDERLY PROJECT
COMMUNITY CARE, INC.

Senator Rubin, members of the Study Committee on Aging, friends, and colleagues, I wish to share with you today the progress, plans, and potential of the Care Coordination for the Health Impaired Elderly Project and solicit your involvement and support to assure its' results benefit the people of South Carolina.

Background:

In 1979 the Robert Wood Johnson Foundation submitted to the governors of the fifty states a request for proposals to establish model demonstration projects in the Coordination of Services for the Health Impaired Elderly. The Foundation, established with funds from the Johnson and Johnson Company fortune, is the largest medical foundation in the country, dispensing over a million dollars a week, and is second only in total size to the Ford Foundation.

The Foundation proposed to fund eight states with a million dollars for a five year period to develop a model central coordinating unit in a local area which included a population of at least 20,000 persons over age sixty-five.

The Governor of South Carolina referred the request to the South Carolina Commission on Aging. Community Care, Inc., in conjunction with the Area Agency on Aging of the Central Midlands Region, prepared a proposal which was approved and submitted as the state's application.

Foundation officials selected it out of thirty-eight state applications for one of twelve site visits and it was funded February 1, 1980 as one of eight states to receive such awards.

Goal:

The goal of Care Coordination for the Health Impaired Elderly Project is to develop and demonstrate a means by which all long term care resources can be coordinated to be most effective in meeting the needs of health impaired persons.

This, of course, requires that persons and agencies of diverse backgrounds learn to work together. The very different disciplines of health care, social services, and mental health must communicate and coordinate. Fifteen agencies and institutions from Richland and Lexington Counties assisted in preparation of the application. The number has now grown to over twenty in the Central Midlands. A listing of these is attached to my testimony, but it includes all the local hospitals, Crafts Farrow State Hospital and the Veterans Administration Hospital; it includes all the local Councils on Aging, the Health Departments, Departments of Social Services, and a number of community based agencies and clinics.

Together Community Care and the Area Agency on Aging have enabled these participating agencies to establish a structure for working together to identify the health impaired and begin to coordinate their services to meet the needs of these persons.

Accomplishments:

During the first year methods of working together were established and 200 clients were assessed by project staff. These assessments provided a profile of the condition of typical clients of all participating agencies, a perspective on the resources available to meet their needs, and identification of the problems and potential for coordination.

The second year began with a conference in March of participating agencies. In it they (1) reviewed the learnings of the first year. They (2) identified the current problems and projected the future impact of an aging population. They (3) planned to develop a uniform way to assess their clients and to coordinate case management and services.

Since then the following has been accomplished:

--A Uniform Assessment Process has been developed. Small demonstration clusters in Richland and Lexington Counties built on scientifically proven instrument* the particular process needed here to meet each agency's needs and at the same time have a standard way of communicating the nature of each persons problems and appropriate approaches to services.

--A User's Manual has been developed and Project staff have trained nearly 600 persons in the participating agencies to use the process. This training is continuing this fall and almost every agency either has or will implement the process by November, 1981.

Experience in the use of the Uniform Assessment Process will be used to refine and perfect the system early in 1982.

--A Client Information System has been established. Each worker sends a copy of their assessment and plan of care to the Project office. With the accompanying signed release of information form, participating agencies can call to see if a person they are working with has already been assessed and is receiving services from other agencies. A copy of the assessment can be forwarded to the inquiring agency worker so they can build on what others have been or are doing with the client.

Further, data accumulated in the Client Information System can be analyzed to determine what services are needed, which are not available, what kind of service plans seem most effective, the number and severity of various conditions, and many, many other bits of information helpful to good management and planning.

--The Natural Supports of family, friends and neighbors is not being ignored by the Project. In fact, a major motivation of Community Care becomming involved in the Project was the study of and work with Caregivers which was reported to the Study Committee on Aging in previous years.

--The Project is currently developing and strengthening the natural supports through two task forces. The first, is a Consortium for the Impaired and their Caregivers (CIC) composed of agencies and professionals who plan and design resources which will help caregivers of the homebound impaired person.

--The second is a Task Force on Volunteers working with the elderly and impaired persons. This task force has held a workshop to train these these volunteers. This training was attended by over 75 people in the midlands, and quarterly workshops are being planned on general as well as specific topics and skills which volunteers need. Perhaps more important 15 or so agencies in the task force are planning and learning how to better use the skills of these volunteers and recruit additional volunteers.

*The Michigan Long Term Care form based on fifteen years of work in the P.A.C.E. Project in Massachusetts and the work of Sidney Katz, M.D., was used along with certain parts of the Monroe County, New York form.

In addition the project is defining a new position on staff for a Community Resources Developer who will help develop ways for the natural supports to be better utilized and supported by the twenty agencies in the formal system.

--Probably the single most significant accomplishment, however, is the committment and cooperation of so many diverse organizations. While the Project Staff provides a range of professional resources (cf. attached Staffing Chart) each of the participating agencies are devoting many hours and days of staff time to this coordination project. Executive administrators as well as line staff are involved.

Plans:

Plans for the immediate future include formation of small demonstration clusters to design and perfect Coordinated Case Management processes. This will be built on the work already done in Uniform Comprehensive Assessment and the Client Information System. Through Coordinated Case Management, persons with complex needs from a number of agencies will receive the attention necessary to achieve reasonable goals and the best coordination of complimentary services.

In addition, plans for regular follow-up and review will be arranged in this process.

Also, this fall the Projects' Community Advisory Council will hold its first Community Leaders Briefing Day in mid-November. This is an initial step to insure that the community is aware of the needs in the long term care field and the progress being made to address these needs.

The longer range plans call for evaluation and revision of the processes developed during 1982, preparation for their independent functioning the following year, and perfection of the model for use elsewhere subsequent to that. In that connection, it should be noted that the Robert Wood Johnson Foundation maintains a contract with an evaluation team from Harvard Medical School which regularly reviews and makes input to the Project, and which will draw the learnings from all eight of the funded projects for national, state, and local policy and planning.

The Potential:

Many immediate direct benefits to clients, the formal system, and the natural supports in the Project area can be anticipated. A few of these are:

--Continuity of care on appropriate and economical settings;
--Greater and better utilization of community services as alternatives to institutionalization;
--Better allocation of funds and other resources to the most needed and productive services;
--Greater participation of the community in caring for impaired persons.

Other broader benefits can also be anticipated:

--A model structure for agencies to work together at the local level;
--A viable process for assessing and serving impaired persons in a coordinated manner;
--Proven methods for the formal service system to support and utilize the natural resources in the community;
--A means for local coordination activities to mesh with and implement state policies and procedures in a unified and productive manner.

To these ends the Project is working closely with state as well as local agencies. Reports have recently been made to the South Carolina Commission on Aging and to the Long Term Care Council. Attention is being given to working cooperatively with state planning for long term care services so that the people of South Carolina can fully benefit from the Care Coordination for the Health Impaired Elderly Project.

PARTICIPATING AGENCIES
CARE COORDINATION FOR THE HEALTH IMPAIRED ELDERLY
COMMUNITY CARE, INC.

Baptist Medical Center of Columbia

Central Midlands Regional Planning Council

Chapin Medical Center

Columbia Area Mental Health Center

Columbia Urban League, Inc.

Community Care, Inc.

Crafts-Farrow State Hospital

Family Service Center

Lexington County Comprehensive Aging Program - Irmo Chapin

Lexington County Comprehensive Aging Program - Lexington

Lexington County DSS

Lexington County Hospital

Lexington County Mental Health Clinic

Midlands District Health Office

Midlands Human Resource Commission

Providence Hospital

Richland/Lexington Council on Aging

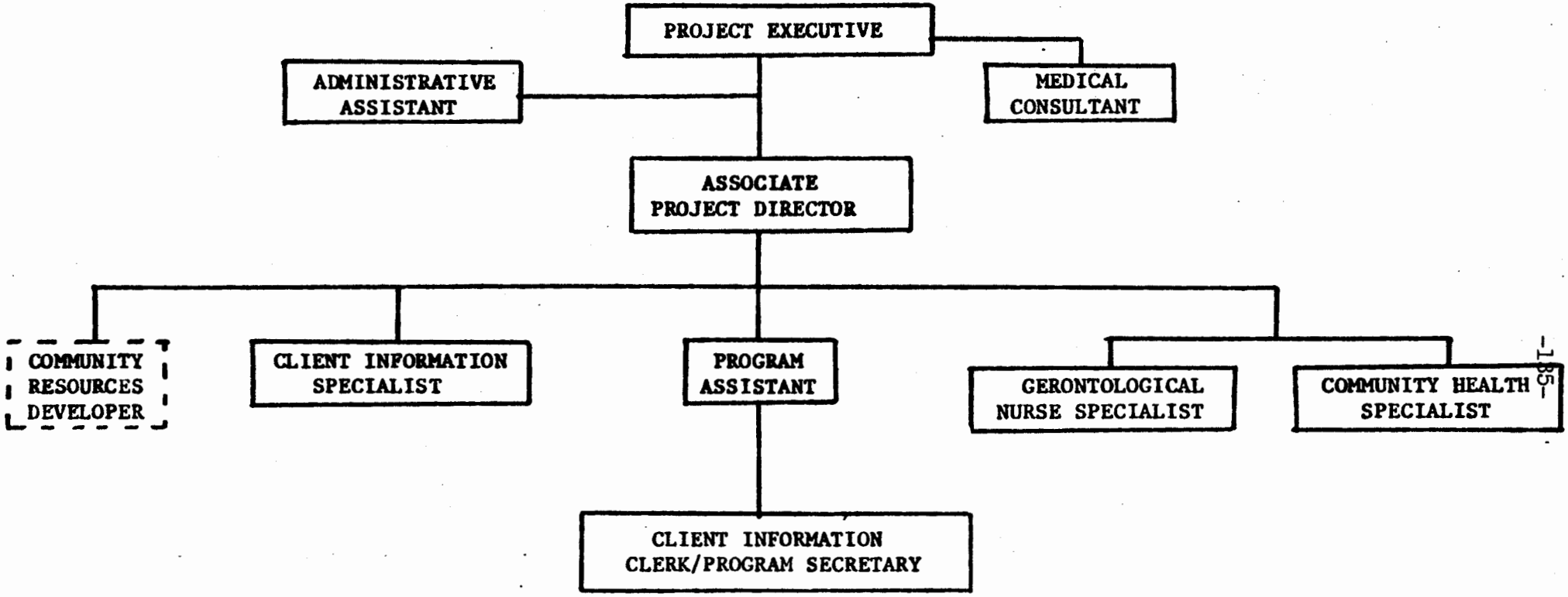
Richland County DSS

Richland Memorial Hospital

South Carolina Medical Care Foundation (P.S.R.O.)

W.J.B. Dorn Veterans Administration Hospital

STAFFING CHART
HEALTH IMPAIRED ELDERLY PROJECT
JULY 1981



Ms. Phyllis Pellerin, Director
Aiken Area Council on Aging
Aiken, SC 29801

This testimony presented two concerns :

1. Tax Commission to permit volunteers the same mileage deduction rate as allowed for business.
2. Investigate the homemaker services before DSS contracts with private for profit corporations to purchase them.

Mrs. Pellerin opposed the use of tax monies to buy services from profit-making organizations when quality services are available and the mechanism for delivering them is already in place with nonprofit agencies.

(Statement on the following pages).

Senator Rubin agrees that some type of assistance to the volunteers is certainly needed. However, the annual growth of revenue is now at 10 percent, down from 15 percent during the 70's. Out of this come the salary increases, the School Finance Act and debt service which does not leave much leeway. "The merit is there and it will have to be met at some time in the future because volunteers are of paramount importance."

Post Office Box 235, Aiken, South Carolina 29801 • Phone: 648-5447

Phyllis G. Pellarin, ACSW
Director, Aiken Area Council on Aging
Testimony to the Joint Legislative Study Committee on Aging
Columbia, South Carolina
September 24, 1981

My testimony today includes two concerns of the agency I represent.

Two years ago when the price of gasoline was $.98 per gallon, a staff member of the Aiken Area Council on Aging appeared before this Committee to request tax relief for the volunteers who drive their own cars at their own expense to provide services to the elderly clients we serve.

Volunteer work is absolutely essential to the work of our agency and to our communities as a whole. In today's society which is recognizing the limits of government, volunteers save taxpayers large amounts of money by performing services that government might otherwise have to provide. If there was a recognized need in 1979, there is an even greater need today. The skyrocketing increases in the cost of gasoline and other vehicle operation expenses have forced many of our volunteers, particularly senior citizens on fixed incomes, to drop out of our volunteer programs that require the use of a car.

We depend heavily on our volunteer drivers, who, during 1980, provided nearly 8,000 hours of volunteer time and drove just under 30,000 miles to deliver services to older South Carolinians. Present state tax regulations discourage volunteers by limiting their tax deduction to $.08 per mile. Yet automobiles used for business purposes are allowed a $.19 per mile tax deduction.

I should like to respectfully request once again that the South Carolina state legislature correct this inequity by permitting volunteers the same mileage deduction rate allowed for business.

Phyllis G. Pellarin

The second part of my presentation concerns the Homemaker service provided by our agency and other Councils on Aging across the State. Briefly, this is a program designed to help individuals maintain themselves in their own homes by using qualified, trained and supervised persons to perform a variety of household tasks and to provide personal care. This inhome, supportive service is a more economical alternative to out-of-home care, and often prevents more costly premature and inappropriate institutionalization.

Many Homemaker programs have been and are now funded with Title XX monies under contract with the Department of Social Services. These contracts have mandated the provision of extensive training to persons employed as Homemakers. There now exists a network of personnel qualified to perform the services under agency supervision throughout South Carolina. Our own agency recently became the first Council on Aging in the State to receive approval from the National Homecaring Council, the recognized accrediting body for high quality Homemaker programs.

We understand that the DSS has been negotiating with private for profit corporations for the purchase of Homemaker services. If contracts are concluded, it is assumed that the programs now in operation throughout the aging network will be eliminated. I should like to go on record as opposing the use of tax monies to buy services from a profit-making organization when quality services are available and the mechanism for delivering them is already in place with nonprofit agencies.

I should like to request that before such a transfer of services is initiated, that a thorough investigation be completed to determine if this is the most cost effective use of tax dollars. It is difficult to see how a profit-making corporation can provide quality services more cheaply than existing non-profit agencies.

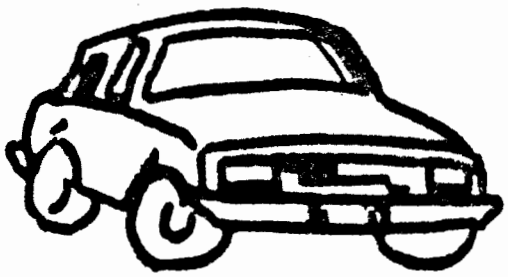
In summary, I should like to request legislative action (1) to provide tax relief for volunteer drivers, and (2) to investigate the Homemaker situation as I have outlined it.

Thank you.

South Carolina State Legislature and

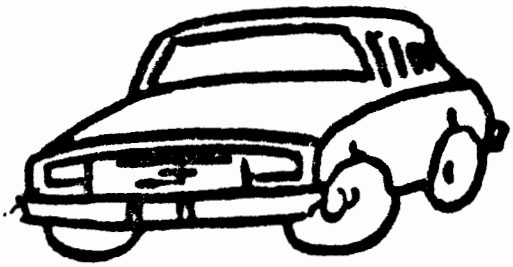
South Carolina Tax Commission
Columbia, South Carolina

$.19 per mile allowed by Tax Commission on this car.



When I drive this car to sell insurance, shoes, or any other business, the Tax Commission allows 19¢ per mile for my car expenses.

$.08 per mile allowed by Tax Commission on this car.



When I drive this car as a volunteer for Home Delivered Meals, a hospital visit, or any other non-profit activity, the Tax Commission allows 8¢ per mile.

WHY?

I am glad to be a volunteer, but out-of-pocket expenses are the same for both errands. Why should they not have the same tax allowance?

As volunteer for the Aiken Area Council on Aging's Home Delivered Meals program, I travel about _____ miles per year. I support and urge passage of a bill increasing the allowance for volunteer driving that will enable me to continue my volunteer work.

My name_____

Address_____

_____

Mr. Clarence E. Geuther
1008 Croft Avenue, NE
Aiken, SC 29801

The subject of Mr. Geuther's presentation addressed two needs:

1. Need for legislation for interspousal intestate inheritance
2. Allowance of homestead exemption for part ownership of property

Senator Rubin informed Mr. Geuther that this Committee was instrumental in introducing legislation which took care of the second part of Mr. Geuther's concerns. He asked Mrs. Bumgardner to mail him a copy of the bill.

Senator McLeod mentioned that the Probate Code will take care of the interspousal intestate inheritance problem.

Senator Rubin acknowledged the presence of Mrs. Sylvia McDonald, wife of the distinguished Senator Heyward McDonald. She is here because of her interest and participation in these matters through the Presbyterian Church.

Sept 20-1981

To: Study Committee on Aging

From: Clarence E. Geuther, 1008 Croft Ave., N.E., Aiken, S.C. 29801

Subject: Needed legislation for interspousal intestate inheritance and for allowance of homestead exemption in certain instances

My late wife and I moved to South Carolina in 1965 and bought a small home in Aiken. Through ignorance, we did not take title as joint tenants but as tenants in common. Again through ignorance, we did not make any wills. We just assumed that if one of us passed away, the other would inherit whatever we had accumulated. My wife then passed away. We had no living children or other issue, but my wife had had a sister who died before her, leaving a son. There was no personal relationship between us and my wife's nephew. After my wife died, I found to my dismay that the nephew had inherited one half of my wife's interest in our home, which left me owning a three fourths interest and the nephew the other one fourth interest. This does not seem fair to me. I subsequently wrote the nephew, asking him to either give me his interest or to sell it to me. He won't even answer the correspondence. I understand that many states have laws providing for interspousal inheritance in the event of intestacy. I realize it will not help me but I would like to propose that South Carolina enact legislation to provide the same. Even if the amount is limited to $25,000.00 or something like that, it would help a great deal. Particularly would it be fair in cases where there is no issue of the deceased spouse and there are only collateral kin involved. I know that it can be said that this can be taken care of by wills but not everybody makes wills. Some people just neglect to do so, some don't know any lawyers, some think the cost will be prohibitive, some just don't want to think about dying.

In reference to the homestead exemption, it appears to me that something less than full ownership should be required. I cannot qualify because I only own a three fourths interest in my own home. The nephew hasn't bothered me so I am able to have the full possession. Under circumstances where an aged person owns a half interest or more in the home and occupies the same solely, it appears to me that the homestead exemption should be allowed. The annual taxes don't increase the value of the property but they do come out of the pocket of the old person occupying the home and the expense is just as much on him as it is on other older persons who are fortunate enough to have full title and right of occupancy.

C E Geuther

Dr. Edward W. Rushton, Executive Director
Orangeburg County Council on Aging
Orangeburg, SC

Dr. Rushton addressed two socio-economic issues which are a part of the 14 major issues of the upcoming White House Conference on Aging.

1. Older Americans as a Continuing Resource.

He is advocating a "job bank" through which business seeks the older worker to fill skilled or semi-skilled jobs, and the older worker seeks employment, such as full time, part time, flexible assignments, seasonal employment and shared job opportunities. The practicality of a "job bank" was shown by a Harris poll of last year which documented that 46 percent of today's retirees would like to continue to work full time or part time. A start has been made by the Federal Government by almost abolishing compulsory retirement as well as by some private companies. Also, Social Security laws have been liberalized so that older workers can earn more money without losing benefits.

2. Housing Alternatives for Older Persons.

He advocates congegrate housing for independent living. He referred to a congregate living center project which the Orangeburg County Council on Aging has been working on for two years to bring about with the help of federal funding and community support. This center will improve the plight of the rural elderly and will become a reality as soon as the FHA approves this project.

He further directed the Committee's attention to the following:

1. State aid should be made available for construction and renovation of senior citizen centers. This should become feasible in view of declining enrollments at schools and universities.

2. Legislate a tax exemption similar to the Homestead Tax Exemption to business, industry and farmers who hire older workers.

3. More adequate housing accommodations are needed statewide, especially in the rural areas.

Senator Rubin said that progress is being made in the area of job opportunities for older persons. This is an educational process in part. He asked him if he has made appeals to the Orangeburg County Council regarding the senior citizens facility.

Dr. Rushton replied that with the community support they are getting they have high hopes of getting a better facility as far as location, size and accessibility. However, what he wants is to have this throughout South Carolina.

Senator Rubin agreed with him, but cautioned that it would be unrealistic to anticipate that the State could inaugurate this program on a statewide basis in the immediate future.

Mr. Chairman, Members of the South Carolina Study Committee on Aging:

I am Edward Rushton. For the past 5 years it has been my good fortune to serve as Executive Director of the Orangeburg County Council on Aging.

In my previous testimony for the last four annual hearings of this Study Committee I have pleaded for state aid in helping to construct and renovate senior citizen centers because they are a port-of-call, a home base whereby needy and worthy older persons may enjoy rich and rewarding experiences during the best years of their lives. With appropriate programs and activities, social relations with peer groups, sharing learning activities in the practical arts, and numerous other relationships that contribute to their well-being, senior centers are indespensible. I am well aware that the tax dollar should be used to meet, in so far as possible, the greatest needs for the greatest number of all South Carolinians; therefore, in view of the fact that the fastest growing segment of our society is now the older person, surely senior citizen centers constitute a priority of need.

Fortunately, the growth and development of our programs and projects in Orangeburg County have been enriched and expanded whereby approximately 50 percent of our 10,600 senior citizens are being served through 16 identifiable offerings. This marked expansion of programs and projects, together with a growing awareness of the benefits for the elderly by our community, we have high hopes of obtaining a more adequate senior citizen center with respect to size, location and accessibility.

Today, I present also two obvious socio-economic issues that deserve renewed interest, enthusiasm and action. They are: Older Americans as a Continuing Resource,and Housing Alternatives. These major concerns are a part of the 14 major issues of the forthcoming White House Conference on Aging.

On two occasions I experienced the trauma and difficult adjustments inherent in being retired due to chronological age -- the first time I was put out to pasture from a public school position and the other was a release from a college professorial staff.

Believing strongly as I do in the American Free Enterprise System and that society does not owe me a living, I sought gainful employment and fortunately got a job working with my age group in a County Council on Aging. If I could be so fortunate, how about other retirees who have much more wisdom and expertise than I and surely valuable experience and stability? It is from my experience and research that I advocate opening up the job market for senior citizens.

Perhaps the time has come for a new relationship between American business and Councils on Aging for mutual benefit. The business community needs the wisdom and talents, the energy and skills of older people, and a large number of senior citizens needs jobs, especially in the light of spiraling inflation, fixed incomes, and a desire to work. Furthermore, the last election and the public mood reveals declining budgets over the years ahead. It becomes important, therefore, that the private and volunteer sectors join hands, form new cooperative alliances, and pool resources of concern and creativity. It appears obvious that necessity requires this combination and it would be good for business.

I am advocating a "job bank" whereby business seeks the older worker for skilled and semi-skilled jobs while the older worker seeks employment, such as full-time, part-time, flexible assignments, seasonal employment and shared job opportunities. The practicability of a "job bank" is shown by a Harris poll released about a year ago that 46 percent of today's retired people prefer to work part-time or full-time. Furthermore, 51 percent of younger workers - today's workers and tomorrow's retirees - expressed a desire to work in some way after they retire. The bottom line seems to suggest that work is good for older people who choose it; good for business; and, good for America.

A cursory look at business establishments across America reveals that a beginning has been made to employ the older worker, that changes in retirement policies have been made, and flexible work assignments have been accepted. These national trends point in the right direction in changing old ideas about work and retirement. For example, the 1978 Amendments to the Age Descrimination in Employment Act wiped out most mandatory retirement ages up to 70; compulsory retirement on the basis of age has been almost

completely abolished by the Federal government and by several states for their own employees; and, Social Security laws have been liberalized so that older workers can earn more money without losing benefits.

On the other side of the coin older people over 65 are faced with arbitrary barriers - age descrimination, restrictive government and corporate policies, transportation problems - that add up to economic penalties for work effort. Less than 21 percent of men aged 65 to 69 worked even part-time last year and fewer than 15 percent of women.

Even though a large segment of the older population may choose not to work, there are too many senior citizens who want to work but can't. Those who want or need gainful employment are healthy, willing, eager and competent.

There are fortunately some innovations that holds promise to help older persons upgrade skills for jobs in changing socio-economic systems. I refer to counselling and job referral of the S.C. Employment Security System, and state supported Colleges, Universities and technical schools that allow senior citizens to attend classes for credit and non-credit on a space available basis without payment of tuition.

Another possibililty for assistance is that some foundations are concerned about innovative programs to improve the quality of life for the aging. Investigation has disclosed that a major thrust of one national foundation will assist programs in the field of aging in 1982. Thereupon, the Orangeburg County Council on Aging submitted a project proposal which will assist the active older worker in finding employment or productive volunteer activity.

With respect to housing alternatives for older persons attention should be directed to components, such as energy costs and efficiency, crime and crime prevention, housing design, health care, nutrition and diet, recreation and social activities. Each of these elements is an issue within itself; however, for this presentation an alternate housing pattern is centered upon congregate housing for independent living. Whatever a housing facility may be called, to the resident it is home.

Congregate housing is more than a low cost, isolated, impersonal and detached physical facility. A congregate living center envisions a warm, caring, safe domicile in a wholesome environment. It should be designed to provide privacy, minimum health care, nutrition services, recreation activities and space for social interaction.

The need to conserve energy, increase efficiency, plan creatively, provide safe environments, and make affordable options and alternatives for respectable housing has never been so paramount, especially for the rural elderly. Studies provide indisputable facts and supporting evidence to show that the older person is in dire circumstances with respect to satisfactory housing accomodations.

In an attempt to help improve the plight of the rural elderly the Orangeburg County Council on Aging has been working for two years to bring about a congregate living center through federal funding undergirded by community support. Should the Farmers' Home Administration approve our project the facility will be architecturally designed to provide privacy in living quarters, nutrition service, outdoor spaces for gardening and walking trails, commons area for social interaction, first aid station and social activities. The location will be in proximity to medical service, shops and stores, churches, and other community facilities and within an established residential section. Clients must be mobile and able to care for their normal physical needs.

I realize that not one of the issues presented in this testimony is new. However, those of us, on the County level where services are delivered, are in daily contact with older people who are suffering and really need help.

As your committee deliberates on a program of action for the well-being of older South Carolinians, I suggest your careful consideration to the following:

(1) In view of declining enrollments of school pupils and soon college/university registrations, state aid for construction of educational facilities may not be as great as formerly; therefore, state aid could be made available for construction and renovation of senior citizen centers of high quality construction - barrier free.

(2) *The Homestead Exemption Act is a blessing to older South Carolinians. Legislating a similar tax exemption to business, industry, and agriculture employers, who hire older workers, could provide the incentive needed to make such a program successful. In turn, the older worker would then produce additional revenues for State, Federal, and Social Security Funds, giving a boost to the economy.*

(3) *More adequate housing accommodations are crucial statewide, particularly in rural South Carolina. Support of your committee for housing alternatives would go a long way in bringing about conscious and deliberate efforts for affordable housing for senior citizens.*

Respectfully submitted

Edward W. Gustafson

September 24, 1981

Ms. Robin Burns, Chairperson
Governor's Council on Volunteerism
Governor's Office

Ms. Burns informed the Committee of the Governor's Council on Volunteerism, which was created in March of 1981. This Council consists of 15 members; representatives from the 12 health and human service agencies and 3 from the private nonprofit sector. A report has been prepared by this Council to be submitted to the Governor this month with numerous recommendations on actions needed to involve volunteers in State government.

She referred to a handout (on file in the Committee) which contains an article describing an unusual approach to volunteerism instituted in New York City. This project was called the Second Careers Volunteer Program. The City of New York actually used older, but skilled and specialized people in volunteer positions in State government, not to replace but to supplement staff. They had over 400 volunteers to register for this program, and they were able to place them throughout the state agencies.

The Governor's Council would like for the Study Committee on Aging to work with them on this project.

Senator Rubin remarked that senior citizens are already doing a lot of volunteer work in many fields. He asked how the Council contemplates organizing this; you would have to have some type of selectivity and method of clearance.

Ms. Burns thinks that is why the Governor's Council is very important. Their role is to implement programs in State agencies for volunteers and she came here today to seek the Committee's interest and support. It would be implemented through State agencies; there are already people in those agencies who have been appointed by the Governor to work on setting up volunteer programs with job descriptions, screening, placement. Ms. Burns is thinking of having these volunteers work on special projects, planning, research. She expressed her hope that the Committee will work with her on this project. Also, the Council will be glad to share with the Committee the recommendations they have made to the Governor, once he approves them.

Senator Rubin told her that the Committee is looking forward to receiving them.

Study Commiteee on Aging
September 24, 1981

Written Testimony of Robin Burns, Chairperson
Governor's Council on Volunteerism

I. What is Governor's Council on Volunteerism?

Governor Riley created the Council on Volunteerism in March of 1981 to explore how the Governor working through the Council could encourage the use of volunteers in state agencies. The Council composed of representatives from the twelve health and human service agencies and three from the private non-profit sector have prepared an initial report to be submitted to him this month with numerous recommendations on actions needed to involve volunteers in state government. The Council is convened for a two year term and plans to work on other plans including volunteers and the private non-profit sector.

II. How the Council relates to the work of the Study Committee?

The members of the Council wish to inform you of our function and bring you an idea to involve older people as volunteers especially in government. In New York City a special project called the Second Career Volunteer Program was set up to serve the vast pool of retirees whose skills and experience, coupled with new found time and leisure, equipped them with unique resources which could be effecticely put to use in the city's many government and non-profit organizations. The three year project was organized with the specific goal of placing retirees with backgrounds in the law, medicine, accounting, business, teaching and other fields in interesting meaningful volunteer assign-

ments. Over 400 retirees volunteered. In an evaluation survey most stated that aiding the community or specifically their town was the most important reason they volunteered.

The Council members would like to suggest that this project is a worthwhile endeavor and ask the Study Committee to join with us in recommending research of this plan for referral to the appropriate agencies and organizations. The Study Committee by lendings its interest and support to working with the Council on this suggestion would give the idea more credibility and a wider audience. We too are interested in the tremendous potential of our older citizens and in view of our shrinking resources it seems an ideal solution to help ourselves with the available and able resources that are found in our older citizen's capabilities.

Mr. Bill Spence
Retired Senior Volunteer Program
Richland-Lexington Council on Aging

Mr. Spence was asked by Ms. Susan Carlton, Director, RSVP, to present this testimony so the Committee could hear a volunteer's point of view. He has been retired twice and is now working with the Retired Senior Volunteer Program. His testimony pointed out how important the Program is to retirees and asked for the Committee's support of their programs in South Carolina.

He mentioned a very worthwhile service which had been started recently and, in his opinion, would not have become a reality had it not been for RSVP volunteers and staff: the Harvest Hope Food Bank.

Funding, of course, is very important to keep up this valuable service, especially for transportation. Those on fixed incomes could not volunteer without the mileage reimbursement that RSVP provides. Ten years of experience, however, has shown RSVP to be very cost efficient at 50 - 65 cents per volunteer hour in South Carolina.

He urged the Committee for legislative action to get larger tax deductions for volunteer mileage.

Attached to Mr. Spence's statement is a copy of a proclamation signed by Governor Riley which designated September 23, 1981, as Retired Senior Volunteer Program Day, which he asked the Committee to endorse.

Representative Barksdale moved that the Committee endorse Governor Riley's statement to RSVP and commend them for the kind of work they are doing.

Senator Rubin agreed with this but asked that it be done at the follow-up meeting when the Committee meets to assess all the suggestions received today. He thanked Mr. Spence and commended him for his fine work.

Testimony - Study Committee on Aging

September 24, 1981

William Spence - RETIRED SENIOR VOLUNTEER PROGRAM

Ladies and Gentlemen,

This year Susan Carlton asked me to make this presentation to give you a volunteer's point of view.

My name is Bill Spence. Twice retired, first from the Air Force and then from the Governor's Office of Economic Opportunity, I am an RSVP volunteer in the Richland-Lexington Program. I live in Irmo.

I came today to tell you about the Retired Senior Volunteer Program, how important it is for those of us who volunteer, and to ask for your support for the programs in South Carolina.

There are now 580 people over 60 doing volunteer work through our RSVP in Richland and Lexington counties. Together we give over 7,000 hours of service each month in 75 different schools, agencies, hospitals, and special projects in the two counties. Among these are seven state agencies and we have recently completed a temporary assignment in the Governor's Office.

My volunteer work has been with the fledging organization, the Harvest Hope Food Bank. You may remember it in connection with the Good Samaritan Legislation passed by the Legislature this year, for which I thank you, by the way. I am very proud to have helped start such a worthwhile and needed service for our community and want to say that I probably would not have found my way to the Food Bank without RSVP. Indeed, I believe that the efforts of the RSVP volunteers and staff were instrumental in making the Food Bank a reality.

This is but one of many areas in which RSVP is involved. The variety of job opportunities is amazing. Life for the staff is a challenging and ever-changing juggling act, matching up skills and needs of each volunteer to the needs of our community. A person over 60 comes in and a job is found for them. If nothing in the files appeals, a search is begun for the place where she or he can be useful. An agency calls and the volunteer

issought to fill the request. Or we become aware of a gap in service and try to find a way to respond with volunteer services, as in the case of the Food Bank.

All this takes time to develop. It takes funding for transportation for those senior volunteers who don't drive. It takes funding for those on fixed incomes who could not afford to volunteer without the mileage reimbursement that RSVP provides. Yet, 10 years experience has shown RSVP's to be very cost efficient with the cost per volunteer hour in the South Carolina programs averaging between 50¢ and 65¢.

1981 is the 10th Anniversary of the founding of RSVP across the nation. I've attached a copy of a Proclamation signed by Governor Riley which designated September 23 as Retired Senior Volunteer Program Day in South Carolina, in honor of this Anniversary. I trust that you would endorse his statement that "...the State of South Carolina believes that its older citizens are a valuable resource to their Communities when given the opportunity to serve..."

I urge you to translate your endorsement into legislative action that encourages voluntarism, such as larger tax deductions for volunteer mileage, or funding for volunteer administrators in state agencies, or statewide recognition of volunteers. Please consider how important it is for South Carolina, part of the sun belt and an attractive retirement spot for growing numbers of older people, to have programs that tap the resources that exist in my generation for the good of all our people.

So far the Retired Senior Volunteer Programs have not received any direct federal budget cuts, but in the event of such cuts I would ask you to be prepared to support the programs with state funds.

At this point I am asking only that you be aware of the good work volunteers are doing through the RSVP's and commit yourselves to furthering the programs whenever possible. We so-called "non-traditional" volunteers are becoming "traditional" volunteers in the place of home-makers who are now at work in paid employment. We have the time and skill if only someone provides the transportation, the structure, the encouragement, the meals or travel reimbursement that makes it possible for us to volunteer in spite of fixed incomes and inflation.

Remember, the Retired Senior Volunteer Program is like Hallmark cards: "We care to send the very best!"

Thank you.

State of South Carolina

Office of the Governor

RICHARD W. RILEY
GOVERNOR

POST OFFICE BOX 11450
COLUMBIA 29211

PROCLAMATION BY GOVERNOR RICHARD W. RILEY

ON

RETIRED SENIOR VOLUNTEER PROGRAM DAY

WHEREAS, the Retired Senior Volunteer Program enables more than 3,400 older South Carolinians to contribute over 450,000 hours of service annually to their communities; and

WHEREAS, 260,000 RSVP Volunteers contribute over 52 million hours of service a year all over the United States of America; and

WHEREAS, the Retired Senior Volunteer Program has contributed to a new and positive image of growing old throughout the nation; and

WHEREAS, the State of South Carolina believes that its older citizens are a valuable resource to their communities when given the opportunity to serve; and

WHEREAS, 1981 is the 10th anniversary of the founding of the Retired Senior Volunteer Program.

NOW, THEREFORE, I, Governor Richard W. Riley, do hereby declare that September 23, 1981, is:

RETIRED SENIOR VOLUNTEER PROGRAM DAY

in the State of South Carolina.

Richard W. Riley

Ms. Leona K. Plaugh
Columbia, SC

The following statement was made in behalf of the Respite House, which is operated by the City of Columbia Housing Authority. This facility is specifically designed for the physically handicapped and Ms. Plaugh attributes her mother's recovery from arthritis and hip surgery to the excellent care provided by the well-trained staff of the Respite House.

STATEMENT BEFORE THE SOUTH CAROLINA
STUDY COMMITTEE ON AGING

I requested to appear before you today on behalf of "The Respite House" operated by the City of Columbia Housing Authority.

My Mother would probably not be alive today if it were not for this valuable service. She was crippled by arthritis many years ago, and had hip surgery. We realized her recovery would be slow and that she should not be alone during the first several months of her recovery. We feared our only alternative would be a nursing home. When advised by the Richland Memorial Hospital social worker of a facility called "The Respite House" specifically designed for the physically handicapped, it was like a dream come true.

My Mother attended Respite House three times a week. Her progress, I felt, can be directly attributed to the patience and encouragement provided by their well-trained staff. Emphasis is placed on mental alertness, as well as physical coordination. Educational lessons are provided to school age children at the center and recreational outlets such as crocheting, cards, and special trips to the zoo and other places are part of the program.

For those of us who have been fortunate enough to become a part of this program, it has brought to our loved ones much more than a mental alertness, physical condition, but a sense of meaning, belonging and true worth.

Programs like these must be supported with our tax dollars, appropriate legislation and our prayers, for otherwise the Senior Citizens of our country who still have much to contribute to our society will end up institutionalized. Respite House is a much better answer.

Reona K. Blough

Sr. Susanne Beaton
Columbia, SC

In calling this speaker, Senator Rubin said that Sister Beaton was chiefly responsible for passage of the Food Bank Bill which Mr. Spence mentioned in his testimony.

Before starting her testimony, Sister Beaton reinforced Mr. Spence's presentation regarding the RSVP. Projects like the Harvest Hope Food Bank and others that will start to grow in the community would not be able to survive without the help of programs like RSVP.

Sister Beaton's testimony focused on housing.

She urged the legislators to pass H-2539, the Uniform Residential Landlord and Tenant Act. There are 3,000 substandard units in Richland County, of which more than one third lack one or more plumbing facility. In the City of Columbia 15-25 per cent of housing is in violation of the local housing code. The passage of above-mentioned bill would establish new responsibilities for landlords and tenants in the care and maintenance of residential property.

As to Condominium Conversion, senior citizens are often the most direct victims, and Sister Beaton expressed her appreciation to the Committee of having had the foresight of introducing controlling legislation, S-289 and H-2517.

She encouraged the Committee to support Federal legislation, H.R.5175, using Federal control of lenders to prohibit loans for conversion or for purchase of conversion units for a three-year period. This measure further amends the Internal Revenue Code and makes developers conversion profits taxable as ordinary income instead of capital gains and allows for a depreciation deduction on the rehabilitation of rental property, which would provide an incentive to maintain rental property.

She called the Committee's attention to S-314, ratified in July, which allows for redevelopment projects in slum and blighted areas. A weak anti-displacement amendment was attached to this measure. Displacement of low-income people on fixed incomes can become very real when redevelopment occurs. Many poor people become victims when this redevelopment is not planned with the present residents in mind.

In closing, she urged the Committee to find creative ways of housing senior citizens and especially those with few economic resources.

Senator Rubin remarked that in his opinion the Condominium Conversion Bill is a comparatively innocent type bill; however, it was held up the whole session due to arguments of free enterprise.

Sister Beaton replied that free enterprise cost the Treasury 30 billion dollars last year in terms of home ownership subsidies. Public Housing only cost one fourth of that.

Senator Rubin thanked Sister Beaton and told her to keep on working.

Mr. Chairman and Members of the South Carolina Study Committee on Aging, I would like to thank-you for the opportunity to share a few thoughts regarding some of the needs of our Aging citizens.

I would like to focus my presentation on housing issues. I do this from the lessons I have learned from my associations with people from Providence Home, a series of shelters, and from my community related work in Columbia, especially with low income people and their struggles to survive with a bit of dignity.

Housing, an affordable, liveable roof over people's heads, is a basic bottom lifeline. Any reading of current history will clearly indicate that the housing market is in a critical situation. With fewer moderate income houses being built, we are witnessing an alarming shrinkage of rental housing. Very often many landlords can exploit such market conditions thus causing a number of things to happen.

Among the problematic areas I would like to deal with are the following: 1) Substandard rental housing; 2) Condominium Conversions and; 3) Displacement.

Substandard Housing

Recent economic and social developments demonstrate the inappropriateness of the continued application of ancient common law rules developed in a world far removed from modern society. Because of the effect of increased demand for rental units (For example, in Columbia, a 10% tenant vacancy rate in the early 1970s has dwindled to less than 1% today.) The undersupply of residential units has encouraged the more disreputable landlords to ignore the dilapidated condition of their properties. The deplorable state of the housing stock in Richland County is well documented. Over 3,000 units are substandard and more than one third lack one or more plumbing facilities. Between 15-25% of the City's housing is in violation of the local housing code.

Many of the people we deal with are caught in the bind of living in poor housing conditions and thus are subjected to extremely high utility bills as they continue to heat the outdoors in an attempt to keep warm. They can't afford to move, they can't afford to pay for repairs, and they can't afford high utility bills. The demand to pay

rent and utilities continues along with the utter powerlessness on the part of the individual to rectify or gain any permanent solution to the underlying problems. Which one of us here would enjoy living with such abuses as leaking ceilings, no hot water, no heat or faulty windows and plumbing?

The remedy is in your hands as legislators. You have the opportunity to look at and carefully consider H. 2539, the Uniform Residential Landlord and Tenant Act. It is presently in the Labor, Commerce and Industry Committee in the House.

Since 1972, 40 States have adopted either by statue or case law the basic concepts incorporated in the Act, while 16 States have adopted the bill without modification. Southeastern States including North Carolina, Georgia, Virginia and Florida also have enacted legislation patterned after the model Act. Essentially, the bill creates new responsibilities for landlord and tenants in the care and maintenance of residential property in South Carolina. Fair treatment and decent housing protections are what the bill is all about. The Realtor Community, Tenant Organizations and responsible Landlords are all recognizing the need to see a more responsive law enacted in S.C..

CONDOMINIUM CONVERSION

With regards to Condominium Conversion, I am grateful that this Committee has had the foresight to begin addressing the problem before it gets out of control as in other states. Senior Citizens are often the most vulnerable and direct victims of condo conversions. S.289 and H. 2517 begins to explore the seriousness of this issue.

The trend toward condo conversion is a major factor in the nationwide decline of rental housing available to low and moderate income citizens. The U.S. Department of Housing and Urban Development states that "the large potential profits which can be made in a relatively short time when compared to new construction make conversion so inviting for investors." Tax benefits encourage apartment house owners to sell. By selling to a condo converter, the owner reaps a premium price over what his building would be worth as rental property. HUD, in its report, observed that most conversions have taken place in areas of low rental vacancies, usually under 5%. It is when a

city faces a severe housing crunch that condos begin to boom.

As the Condo menace spreads, many cities and states have passed or are considering restrictive regulations controlling condo conversion. Some places have passed temporary moratoriums until the problem can be studied further.

Vacancy rate triggers can have the same affect as a moratorium. Recognizing the relationship between rental vacancy rates and the impact of condo conversion, several jurisdictions have established vacancy rates below which condo conversions are prohibited without rental approval. These laws halt condo conversion when a city's vacancy rate falls below a certain percentage, either 5% or 3%. The policy behind this is to bar conversions where there is insufficient rental units available for those who are displaced. Other protections that have been offered are:

- no conversion if the units in the building are part of a city's low to moderate income rental supply
- lifetime tenancy, especially for people 60 years of age and older
- require the converter to provide a certain percentage of low income units in each project
- a reasonable growth limit on either the number of buildings or individual units that could be converted in a 12 month period
- require the developer not the taxpayer to pay the cost of relocation, especially the cost of relocation assistance payments for housing.

Renters receive no tax benefits for their years of rental payments. Perhaps it is now time to make those who make such huge profits under the guise of tax shelters to help bear the economic costs for displacement due to speculation in the housing industry.

I would also encourage this Committee to support Federallegislation, H.R. 5175, to control conversions using federal control of lenders to prohibit loans for conversion or for purchase of conversion units for a 3 year period. It would also amend the Internal Revenue Code to make developers profit from conversion taxable as ordinary income instead of capital gains. This would remove much of the financial incentive for conversion. In addition, it would amend the Internal Revenue Code to allow for a depreciation deduction on the rehabilitation of rental property. This will provide financial incentive to maintain rental property.

DISPLACEMENT

The late 70s and on into the 80s saw and will see the back-to-the-city movement by young, often childless couples. The rising costs of commuting, the disenchantment with suburban lifestyle, lead many to seek out a place to live in older urban neigborhoods (commonly called "gentrification", and for the poor and elderly who get displaced in the process, it is called the "gentrification blues"). S314, which was recently signed into law, allows for redevelopment projects in slum and blighted areas. Fortunately, a rather weak anti-displacement amendment was attached to it. The potential for displacement of low income people on fixed incomes when redevelopment occurs is real (For example, Elmwood Park in Columbia - many were forced to move to make way for the urban pioneers and redevelopment.). Many poor people become the victims if redevelopment is not planned with the present residents in mind. This legislature has the power to put a human face on development in this State. I have witnessed many people being displaced in the name of progress. I pray that this pattern won't be reproduced across the State.

In closing, I would encourage your Committee to explore creative ways of housing our Senior Citizens, especially those with few economic resources. The future is fearful enough for many Seniors without the added fear of having "no place to lay their heads" or if they have one, wondering whether it will be an affordable or decent place to lay their heads. With the federal cutbacks in housing, the private sector must become part of the housing solutions.

Mr. Dennis Caldwell, Executive Director
Three Rivers Health Systems Agency
Columbia, South Carolina

The purpose of this Agency is to develop long range plans for all health care services so that quality care at affordable prices is made available to all people.

In light of reduced State and Federal funding, Mr. Caldwell's presentation dealt with the problems which affect the health of the elderly as well as the entire structure of the health care system.

Over two-thirds of all health care costs for the aged are paid for by public funds and, therefore, it is not surprising that interest is focused on this population group. Medicare, Medicaid as well as other insurance programs have not resolved the health cost problems of the elderly.

Three Rivers HSA believes that two inseparable problems exist in the nursing home industry: 1) high costs, and 2) lack of available beds. Mr. Caldwell presented two recommendations to improve these problems without diminishing quality care. These recommendations should be tested either through demonstration or pilot projects.

1. Appropriate placement of patients corresponding to their level of care is essential to containing costs and insuring available beds. Almost 20 percent of patients in nursing homes do not require institutionalization for medical reasons--they are there for lack of alternatives. Here, Mr. Caldwell praised the Committee for their efforts and the progress made with the Long Term Care Project. However, their concern is with the patients residing in nursing homes and inappropriately placed there. These patients could be staying in a less expensive setting.

If money could be saved on the institutional side of long term care, then additional services could be established in the non-institutional setting, such as home care, day care and residential care.

2. Three Rivers HSA is recommending to shift over to boarding homes the 20 percent of the nursing home population needing a different level of care. It is difficult to attract investors to build additional facilities because of the low reimbursement rate. If operators could receive a higher

reimbursement rate per patient, programs could be expanded and standards upgraded, and patients might choose this setting as an alternative over more institutional settings.

In order for this new level of care to be reimbursed by health care dollars, licensure as a health care facility would have to be sought. At present, boarding home operators are reimbursed from Supplemental Security Income payments.

This additional level of care is not a new idea. Several states, including Florida, Texas, Arizona and Kentuckey have three levels of nursing home care. Since boarding home costs will be less than half of nursing home costs, significant savings could be realized.

Senator Rubin wondered how the State would handle the reimbursement to the boarding homes.

Mr. Caldwell explained that the boarding homes would have to be upgraded to receive the patients and, therefore, they may lose the name boarding homes and may be called something else. But the facilities are out there called boarding homes, you may not have to build new ones. Reimbursement would be received from Medicaid. The savings they foresee would come from the transfer of the 20 percent of patients out of nursing home beds and this way you save $10-14 per day. These savings could be used to pay for those boarding homes and any additional beds.

Senator Rubin asked if you need a Certificate of Need to build boarding homes.

Mr. Caldwell replied that a CoN was not necessary as there is no nursing care. What they are saying is use the boarding homes, use that facility and create a new category. You may want to call it Category Three. You could build a new facility, but that would not have to have as much nursing and rehabilitation services, and the reimbursement rate, which would come from DSS under Medicaid, would be lower. Another option would be for DSS-every year when they develop contracts-to say to the nursing home industry this year instead of 1200 nursing beds we need only a 1000 and ask for the other 200 at a less expensive rate, such as a boarding home rate or a Level Three. These 200 could be reimbursed at that rate, cut their staffing back and save the State money.

Senator Rubin thought this might be a valuable idea, the Committee will follow up on this as best as it can.

Mr. Caldwell expressed his appreciation for being here and offered Three Rivers HSA's assistance.

TESTIMONY TO

SOUTH CAROLINA STUDY COMMITTEE ON AGING

SEPTEMBER 24, 1981

Senators, Representatives, Committee Members and Staff:

Thank you for the opportunity to speak on behalf of the problems and concerns of South Carolina's older citizens. The emphasis of my presentation today deals with problems which affect the health of the elderly, as well as the entire structure of the health care system, in light of reduced state and federal funding.

For purposes of introductions, my name is Dennis Caldwell. I am Executive Director of the Three Rivers Health Systems Agency in Columbia, South Carolina. This Agency is a federally funded grass roots organization which develops long range plans for all health care services, so that people can receive quality care at affordable prices.

The rapid growth of the elderly population during recent years has had major repercussions in the health care field. This fact has obvious implications for the increased need for health and support systems. As a group, the elderly are more likely than younger people to suffer multiple, chronic, often permanent conditions that may be disabling. Since the incidence of chronic and disabling conditions rises rapidly with age, the demand for health serv-

ices also rises. Meeting the needs of the elderly and chronically disabled requires a wide array of medical, social and support services which include institutions, the home and the community.

Since the aged are disproportionately high utilizers of health care and since over two-thirds of all health care costs for the aged are paid for with public funds, it is not surprising that there is considerable interest in this population grouping. The elderly, as a group, are the highest per capita health care consumers. Medical care prices have consistently increased faster than the general cost of living and contrary to popular thinking, Medicare, Medicaid and other health insurance programs have not resolved the health cost problems of older people.[1] In light of recent federal policy changes in health insurance programs, the elderly will be paying higher premiums and hospitals will become more discriminating in their choice of patients as financial caps will be a determinant in patient selection.

Because only five percent of the present aged population are institutionalized, there is an unfortunate tendency to minimize the importance of nursing homes when analyzing the health delivery system. Three Rivers Health Systems Agency believes that two inseparable problems exist in the nursing home industry: high costs and lack of available beds. Today, I would like to present two recommendations which could improve upon availability and cost without jeopardizing quality care. These recommendations should be tested through either demonstration or pilot projects. They are not to be viewed, however, as a panacea for the current nursing home problem.

Adequate documentation exists to demonstrate that almost 20 percent of patients placed in nursing homes do not require institutionalization for medical reasons. People are placed in nursing homes because there are no alternatives available. At this point, I would like to praise you for the progress and efforts you are making in the area of community long term care. This is the other necessary side of the picture that needs to be explored. But our concern here is with the patients residing in nursing homes who are inappropriately placed in that setting. Three Rivers Health Systems Agency believes that appropriate placement of patients corresponding to their level of care is vital to containing costs and insuring available beds.

We are experiencing a situation where there are patients staying in nursing home beds when they could very well be maintained in a less expensive setting. Our hospitals have waiting lists of patients who have been discharged to a skilled care facility but cannot or will not be admitted for various reasons. Quite often the medical status of a patient will prevent his acceptance into a nursing home. He may be "too difficult" to take care of. This stressful situation causes undue financial burden to the hospital who must charge or absorb the full costs of acute hospitalization. The patient and family are concerned about future rehabilitation and finances, and the physician cannot admit an acutely ill patient to the hospital because all the beds are occupied.

In our present system, few dollars are available for community based resources. If money could be saved on the institutional side of long term care, then additional services could be established in the non-institutional setting

(that is, home care, day care and residential care). This is the overall theme of Three Rivers Health Systems Agency. Two directions are recommended for the balance between availability and cost of nursing home beds. We are recommending to shift over to boarding homes that 20 percent of the nursing home population needing a different level of care. Still, the construction of additional skilled and intermediate care beds may also be needed. We want to make available additional beds. But we also want to reduce the cost of nursing homes so that existing funds will pay for these new beds. At the same time, we wish to insure quality of care and safety for all patients.

Today, boarding homes are similar to the nursing homes of over a decade ago, in that it is difficult to attract investors to build additional facilities because the current reimbursement rate is too low to make a profit. If operators were to receive higher reimbursement per patient, then therapeutic and recreational programs could be expanded, monies would be available to upgrade quality and staffing standards, and patients might choose this setting as an alternative over more institutional settings. The increased reimbursement might also prove cost-effective for new construction. Three Rivers Health Systems Agency supports the building of boarding home beds to serve patients who have health needs that fall below intermediate care services. In order for this new level of care to be reimbursed by health care dollars, licensure as a health care facility would have to be sought. Presently, boarding home operators are reimbursed from Supplemental Security Income payments. For this new level of long term care to be implemented, medical, social, financial and licensure agencies should begin to develop licensure and certification requirements. This idea of an additional level of care is not new. Several states, including Florida, Texas, Arizona and Kentucky, have three levels of

nursing home care. We believe that significant savings can be realized here since boarding home costs will be less than one half of nursing home costs.

As you can understand, the State of South Carolina has a crucial role in the development and maintenance of nursing home beds. The Department of Social Services contributes financially to nearly 85 percent of all nursing home patient care through Medicaid. The Department of Health and Environmental Control licenses all nursing homes and has the statutory authority to approve construction of additional nursing home beds through the Certificate of Need program. The state must, therefore, assure that its policies are responsive to the needs of the elderly both in terms of quantity of nursing home beds and quality of care provided. At the same time, the state must consider the taxpayers who pay for much of the nursing home care in the state. In its role as the primary public payor for services in a predominantly private industry, the state must maintain a careful balance between its social responsibility to the elderly (as reflected in nursing home bed approval, licensure and reimbursement) and its fiscal responsibility to the taxpayers.

When planning for health care services for the elderly, a comprehensive system that will foster continuity from one level of care to another must include a full array of health care services. Three Rivers Health Systems Agency believes that by constructing more boarding homes as well as nursing homes, then the choices and alternatives available to patients will result in better utilized, cost-effective services that more closely meet the health and support needs of

the older citizen. We will be glad to work with this committee in any way possible to assure that appropriate care is available and received by those in need.

[1]Pegels, C. Carl, Health Care and the Elderly, Aspen Systems Corporation, 1981

Dr. Charles Laurie
4214 Bethel Church Road
Columbia, SC 29206

Dr. Laurie wanted to make one recommendation to the Committee, dealing with age discrimination in employment. Even though it is illegal, it is freely practiced.

He recommended that the State institute a quota system in employment similar to that being used to prevent race discrimination.

Senator Rubin asked if he was a medical doctor.

Dr. Laurie told him that he is a Professor of Business Education when he is employed, and a consultant and writer when he is not employed.

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This concluded the Public Hearing

Mr. Arthur Stone
P. O. Box 669
Florence, SC 29503

Mr. Stone's testimony was mailed in. It contains recommendations regarding shopping routes and group homes.

(Written statement on the next pages).

Mr. Arthur A. Stone
P.O. Box 669
Florence, SC 29503

September 11, 1981

Ms. Keller H. Bumgardner,
Dir. of Research and Adm.
P.O. Box 142
305 Gressette Building
Columbia, SC 29202

Dear Ms. Bumgardner:

I thank you for your sending me a form to allow me to present some of my ideas to the Study Committee on Aging, but, due to my move from Aiken to Florence, and, other items, my finances are so poor, a good sneeze would foulup my finances.

Thus, travel to Columbia is out of the question for me, at this time.

But, I expect from the booklete you sent me, "State Services for Senior SC"..the Study Committee is well concerned with the program, and I could very well present my ideas, to/through you, and it will get some sort of hearing.

I believe a "Bill of Rights" is required, for older people, (I dont like the term 'Senior Citizens')...so that, in no case can any person, determine, a older person violated the 'system' rules or regulations, find you guilty and punish, all in one minute phone call.

That, any 'violation' must be determined by a Director, Social Worker, and members of their peer group.

That various Councils on Aging, must conform to certain democratic principals, as is normal in the USA and constitution.

That, in regards to transportation, it must not (as in Florence), transport people to specific stores, but to specific AREAS....or.....here we have a number of Malls, some with thirty stores, others, about seventy, others much less, to deny a older person the RIGHT to shop as they so please with no special day, for buying drugs, groceries, underwear, booze or anything else, so, if a person goes to a drug store, across from a supermarket, they must NOT enter the supermarket, but must make two trips, or if shopping for clothing, must decide, via mind reading, what store has her/his item, in advance, or, it will take months for them to find the right store, if, say, I decide on a coat, there is 5 stores selling coats, I can go only to one store at a time, or five weeks, to cover all the stores.

That the rules, must be based on logic, no one, shops in a mall, for a bottle of toothpaste or mouth wash; you buy these items while shopping for some other items, and especiallly older people

should not be made to feel they are accepting charity, by using transportation, with all kinds of idiotic rules.

One can say, only one trip a day, or week, to save gas, to a specific area, mall, but NOT to a specific store.

Thus, I think, all so-called systems should get either a ok from some central group, or from the members of that organization after discussion by its membership.

As the Reagan cuts become effective, shortly, a reduction in services, transportation, etc is clear. Thus wasting gas, wasting personnel is criminal, thus, I think, at least three people should be in every bus, each time a load is delivered to an area.

Specific days for specific areas, sounds logical, but specific days for specific stores does not.

Section 8 funds, are presently not available to those residing in furnished apartments, I am informed, in many cities the only affordable housing is in these furnished apartments, or in specially built projects, which are far to few.

In many cases, these furnished Apt. places are located in downtown, poor locations, which is more suitable to older people in cities. Placing older people in newly built projects, seems fine in theory, but, in actuality, with puting your junk into a newly built home, makes your furniture look worse then you actually thought it to be.

Having served with the Social Services for some years, it, enabled me to understand moreso this problem, and how it affects older people mentally. They prefer being with their own kind, own community, places they know, rather then placed in a castle away from everything they knew.

Lastly, I had a idea that, scared me to death, but, it sounds logical to me, altho I dont yet, know how to implement it.

Why, not buy, rent, a house, a vacant house, small, suitable for one or two older people, by some agency, or both private and governmental groupings, BUY the house, make the repairs, on a thirty year mortgages, and then rent to the older person, at cost, or slightly above, and as they die off, rent to another, thus, the people are housed, FmHA could make the loan to the agency, grouping, it costs them nothing, older people have a home, RE people are happy, everyone is smiling, and government loses nothing.

I hope these ideas are discussed, and prove fruiful.

Sincerely,

Arthur A. Stone